Supreme Court, U.S.
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No. OFFICE OF THE CLERK

In The

Supreme Court of the United States

October Term, 1996

SUSAN A. BJURMAN and GEORGE A. BJURMAN,
Co-Executors of the Will of Dorothy M. Bjurman,

Petitioners,

v.

TRANSAMERICA CORPORATION EMPLOYEES
HEALTH CARE PLAN,

Respondent.

**On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit**

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Irrespective of whether an employee benefit plan is insured or self-funded, ERISA[1] requires the plan administrator to furnish plan beneficiaries with a summary plan description ("SPD"). A SPD must be written accurately to "reasonably apprise" the "average plan participant" of his or her rights under the plan, including the "circumstances which may result in denial" of benefits. 29 U.S.C. §§ 1022(a)(1) and 1022(b). In respect of the foregoing, the questions presented by this case are:

1. Whether it is reasonable, and therefore not an abuse of discretion, for the administrator of an ERISA-regulated benefit plan to interpret and apply an ambiguous exclusionary term contained in a SPD against the reasonable expectations of the plan's beneficiaries.

2. Whether it is improper for a court to apply the federal common law rule of contra proferentem to construe an ambiguous exclusionary term contained in a SPD against the administrator of an ERISA-regulated benefit plan.

3. Whether it is reasonable for a benefit plan administrator to deny benefit coverage on the basis of an undefined, ambiguous exclusionary term contained in a SPD, where under the definition of the term in an analogous and related federal statute coverage exists as a matter of law.

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[1] Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.*

LIST OF ALL PARTIES TO THE PROCEEDING

Plaintiffs and appellees below, and petitioners herein, are Susan A. Bjurman and George A. Bjurman, co-executors of the Will of Dorothy M. Bjurman.

Defendant and appellant below, and respondent herein, is the Transamerica Corporation Employees Health Care Plan, an employee benefit plan as defined by 29 U.S.C. §§ 1002(1) and (3).

The caption of this case contains the names of all the parties to the proceeding in the United States Court of Appeals for the Ninth Circuit.

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PETITION FOR WRIT OF CERTIORARI

Petitioners, Susan A. Bjurman and George A. Bjurman, respectfully pray that a writ of certiorari issue to review the memorandum disposition of the United States Court of Appeals for the Ninth Circuit, filed and entered in this case on March 13, 1997.

ORDERS BELOW

The orders of the lower courts are reproduced in the attached appendix, beginning at App. 1. The Ninth Circuit reversed the orders of the United States District Court for the Central District of California in an unpublished memorandum, filed March 13, 1997. App. 1. On March 27, 1997, petitioners timely filed a petition for rehearing and suggestion for hearing en banc which was denied by an order of the court of appeals, filed April 25, 1997. App. 3. The unreported order of the district court granting plaintiffs' motion for summary judgment was filed on June 8, 1995, App. 4, and amended on September 28, 1995. App. 33.

BASIS FOR JURISDICTION IN THIS COURT

This petition is timely filed pursuant to Supreme Court Rule 13.3 in that the Ninth Circuit's denial of the petition for rehearing was filed on April 25, 1997. This Court has jurisdiction to review the memorandum disposition of the court of appeals under 28 U.S.C. § 1254(1).

Subsections (iii) and (v) of Supreme Court Rule 14.1(e) are inapplicable to this petition.

STATUTES AND REGULATIONS INVOLVED

The relevant portions of the statutes and regulations involved in this case are set forth in the attached appendix, beginning at App. 49. The statutes are: 29 U.S.C. §§ 1001(a) and (b); §§ 1002(1), (3) and (8); § 1003(a)(1); § 1021(a)(1); § 1022(a)(1); § 1022(b); § 1024(b)(1); § 1132(a)(1)(B); and § 1132(e). The regulations are: 29 C.F.R. § 2520.102-2(a) (1988).

STATEMENT OF THE CASE

The questions presented by this case arise under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*,[2] which regulates various types of employee benefit plans.

A. The Subject Benefit Plan

At all times relevant, respondent Transamerica Corporation Employees Health Care Plan (the "Plan") was an

[2] Unless specified otherwise in this petition, all citations or references designated by "§ ___" are to sections of Title 29, United States Code.

"employee welfare benefit plan" under ERISA. § 1002(1).[3] The Plan provided medical benefits to employees and retirees, and their respective dependents, of Transamerica Corporation and its subsidiaries (collectively, "Transamerica"). However, any individual who was a member of a labor union and covered by a collective bargaining agreement was ineligible for the Plan.

The Plan was funded by contributions from Transamerica and the Plan's beneficiaries. Contributions to the Plan were held by a trust which funded benefits. The Plan was "self-funded" in that it did not purchase a policy of insurance to satisfy claims for medical benefits. However, in respect of beneficiaries covered by the Health Insurance for the Aged and Disabled Act ("Medicare"), 42 U.S.C. § 1395 *et seq.*, the Plan coordinated its benefit claims with Medicare. In this respect, the Plan operated as a "Medicare Supplement Plan," paying medical benefits only secondarily to Medicare.

The January 1989 supplement to the Plan's summary plan description (the "1989 SPD"), apprised retiree beneficiaries of their "home health care" benefits as follows:

> Remember that primary coverage for retirees and dependents age 65 or older is provided by Medicare. The Retiree Health Care Plan pays benefits only after Medicare has paid.
>
> . . .

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[3] Pursuant to § 1002(3), the terms "employee benefit plan" and "plan" include an "employee welfare benefit plan" defined by § 1002(1).

- Home health care will be covered at 100% when prescribed instead of a continued stay in either a hospital or an extended care facility. Home health care must be medically necessary and does not include *custodial care* such as feeding, bathing, or administering medication.

Emphasis added. Nowhere in the 1989 SPD (or the basic Plan document) was the exclusionary term "custodial care" further defined. However, the term was defined in a SPD issued in 1993, subsequent to the death of the claimant in this case. App. 25.

The Plan was administered by a committee of five individuals (the "Plan Committee"), appointed by the chief executive officer of Transamerica. The Plan Committee had "all power necessary to supervise the administration of the Plan and to control its operation in accordance with its terms, including . . . the power[ ] . . . [t]o interpret the provisions of the Plan and to determine any questions arising under, or in connection with the administration or operations of, the Plan. . . . " The claims administrator of the Plan was Prudential Insurance Company of America ("Prudential"). The Plan provided that benefit claims denied by Prudential could be appealed to the Plan Committee.

B. The Subject Benefit Claims

Petitioners are the surviving children of Dorothy Bjurman ("Mrs. Bjurman"), and the co-executors of her Will. Mrs. Bjurman died on December 24, 1992 at age 85. At all relevant times, she was a beneficiary of the Plan as the widow of a Transamerica retiree.

During four separate periods in 1992, each following a hospital stay, Mrs. Bjurman was transferred to her home in Los Angeles and placed under home health care prescribed by her physicians. In lieu of home health care, Prudential's claims personnel and the Plan's doctor offered to provide her with care in a skilled nursing facility ("SNF"). She refused the offer and continued with the home health care ordered by her doctors.

Claims for the costs of Mrs. Bjurman's home health care were presented to the Plan for payment. All but a nominal portion (three visits by a registered nurse a week) of the claims were denied by Prudential. Petitioners twice appealed the denials to the Plan Committee. In each instance (the latter on March 30, 1993), the Plan Committee denied petitioners' claims on the ground that the care provided to Mrs. Bjurman was "custodial care" and not covered under the Plan. App. 22.

C. The Proceeding and Disposition in the District Court

In July 1993, petitioners filed this action under § 1132(a)(1)(B) to recover the costs of the medically prescribed home health care provided to their mother. In January 1995, the parties filed cross-motions for summary judgment in the district court, which granted summary judgment to plaintiffs. App. 4 and 33. The district court stated alternate bases for its judgment.

First, the district court reviewed de novo the custodial care exclusion contained in the 1989 SPD (page 4, *supra*), and determined that it was susceptible of two

distinct meanings. Because each meaning was a reasonable interpretation of the exclusionary language, the court found the exclusion to be ambiguous. App. 15-19. *See Wahlin v. Sears, Roebuck & Co.*, 78 F.3d 1232, 1235 (7th Cir. 1996). One interpretation provided coverage for Mrs. Bjurman's care; the other interpretation, that applied by the Plan Committee, did not. Citing *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990), the court applied the rule of contra proferentem and held that it could not defer to the Plan Committee's interpretation. App. 19.

Second, the district court reviewed the Plan Committee's denials under the abuse of discretion or arbitrary and capricious standard. App. 19-20. The court found the Plan Committee's interpretation of the custodial care exclusion rested on a definition of custodial care not contained in the 1989 SPD, and was in conflict with the terms of coverage for home health care. App. 22-26. The court also found as a matter of law that the care prescribed by Mrs. Bjurman's doctors was not custodial care under the criteria of Medicare, App. 29, n. 16 (the health insurance supplemented by the Plan; see page 3, *supra*).

The district court held that the Plan Committee abused its discretion in that its construction of the custodial care exclusion violated both the Plan's provisions and the "reasonable expectations" of its participants. App. 22-26; App. 24, n. 12. The court further concluded that the Plan Committee abused its discretion because the administrative record lacked "substantial" evidence to support the denial of the claims under the custodial care exclusion. App. 31.

D. The Proceeding and Disposition in the Court of Appeals

On appeal to the Ninth Circuit, respondent argued that the rules of contra proferentem and reasonable expectations were "insurance doctrines," and therefore inapplicable in reviewing a plan administrator's denial of benefits under a self-funded ERISA plan. Respondent also contended that substantial medical evidence supported the Plan Committee's decision.

On March 13, 1997, the court of appeals issued its memorandum disposition reversing the district court judgment. App. 1-2. The Ninth Circuit specially classified the Plan as a "self-funded" plan which "expressly delegates to plan administrators the right to interpret ambiguous provisions."[4] *Id.* The court then squarely held that because of the Plan's classification, the district court had improperly applied the doctrines of contra proferentem and reasonable expectations to the custodial care exclusion. *Id.* The court ruled that the district court should have deferred to both the Plan Committee's "reasonable interpretation" of the custodial care exclusion, and its "reasonable conclusion" regarding the medical evidence. *Id.*

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[4] In the interest of brevity, this special class of benefit plans defined by the Ninth Circuit is hereinafter sometimes referred to as "self-funded, administrator-discretion" plans.

E. The Bases for Jurisdiction in the Lower Courts

Jurisdiction in the district court was properly based on 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e), in that the action sought to recover benefits due a beneficiary of an ERISA-regulated employee benefit plan. Jurisdiction in the court of appeals was properly based on 28 U.S.C. § 1291, in that the summary judgment entered by the district court in favor of petitioners was final and appealable.

REASONS FOR CERTIORARI

I. THE DECISION OF THE NINTH CIRCUIT THAT THE FEDERAL COMMON LAW DOCTRINE OF REASONABLE EXPECTATIONS DOES NOT APPLY IN A SPECIAL CLASS OF ERISA BENEFIT DENIAL CASES PRESENTS IMPORTANT QUESTIONS OF FEDERAL LAW THAT HAVE NOT BEEN, BUT SHOULD BE, SETTLED BY THIS COURT

A. The Statutory and Case Law Issues Involved

The purpose of ERISA is to protect the "continued well-being and security of millions of employees and their dependents" covered by employee benefit plans. § 1001(a). Congress intended to fulfill this purpose, in major part, by requiring the disclosure of essential information to benefit plan beneficiaries. § 1001(b).

The disclosure provisions of ERISA are detailed and articulate. The administrator of an employee benefit plan is required to furnish beneficiaries of the plan with a summary plan description ("SPD"), which describes the

"circumstances which may result in denial or loss of benefits" under the plan. §§ 1022(b) and 1024(b)(1). The SPD must be "written in a manner calculated to be understood by the *average* plan participant, and . . . sufficiently *accurate* and comprehensive to *reasonably apprise* . . . beneficiaries of their rights . . . under the plan." § 1022(a)(1); emphasis added; *see also* 29 C.F.R. § 2520.102-2(a) (1988).

Only common sense is required to draw the corollary that plan beneficiaries will necessarily acquire reasonable expectations from being reasonably apprised. Thus, the doctrine of reasonable expectations is undeniably implicit, if not explicit, in the language of § 1022(a)(1).

The district court in this case found that the Plan Committee's interpretation of the custodial care exclusion violated the reasonable expectations of the plan beneficiaries. App. 22-26; App. 24, n. 12. The court of appeals did not disturb the district court's finding. Instead, the Ninth Circuit simply ruled that the federal common law doctrine of reasonable expectations did not apply because the Plan was a self-funded, administrator-discretion benefit plan. App. 1-2. The language of the memorandum indicates clearly that the court's decision is premised upon the law requiring that deference be given to the discretion of plan administrators.

Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101 (1989), held that de novo review of a plan administrator's denial of benefits is required, unless the benefit plan gives the administrator authority to construe terms of the plan. *Id.* at 115. Numerous cases since *Firestone* have established that where a plan administrator is accorded

discretionary powers under the benefit plan, the courts are limited to the abuse of discretion or arbitrary and capricious standard in reviewing the administrator's actions. This standard requires that a plan administrator act reasonably. *See Barnett v. Kaiser Foundation Health Plan, Inc.*, 32 F.3d 413, 416 (9th Cir. 1994).

Neither *Firestone*, nor any subsequently published federal court decision concerning the abuse of discretion standard of review, holds that the courts must defer to a plan administrator's interpretation of a SPD provision that violates the reasonable expectations of the plan's beneficiaries. *Firestone* itself is materially distinguishable from the instant case in that Firestone's interpretation of its SPD did not violate the reasonable expectations of the plan's participants.

Nothing in ERISA or the case law expressly exempts self-funded, administrator-discretion plans from compliance with the statute's SPD disclosure requirements. § 1003(a)(1). Yet, the Ninth Circuit has created just such a special class of benefit plans, and ruled that the beneficiaries of such plans are not entitled to the protection of the federal common law doctrine of reasonable expectations. App. 1-2. As to these benefit plan beneficiaries, the court's decision effectively nullifies their statutory rights to be reasonably apprised in SPDs of important matters regarding their benefits, including exclusionary terms.

B. The Present Conflicts in the Courts of Appeals

The Ninth Circuit adopted the federal common law doctrine of reasonable expectations in *Saltarelli v. Bob*

Baker Group Medical Trust, 35 F.3d 382, 386-387 (9th Cir. 1994). A key factor in the decision was that "protecting the reasonable expectations of insureds appropriately serves the federal policies underlying ERISA, including provision of adequate information to plan participants. . . . " *Id.* at 386 and n. 1. Although the court used the terms "insureds" and "insurance" in the opinion, it is significant in relation to the holding in the instant case that *Saltarelli* actually involved a SPD issued by a *self-funded* medical benefit plan where the benefit denial was made by the plan administrator. *Id.* at 387, n. 9.

Since *Saltarelli*, the federal common law doctrine of reasonable expectations has been accepted by other courts of appeals in ERISA benefit denial cases. Further, the doctrine has been applied irrespective of whether the plan involved was self-funded or insured, or whether the de novo or abuse of discretion standard of review was applicable. *See, e.g., Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 443 (3rd Cir. 1997) (self-funded plan; abuse of discretion standard applied) ("legitimate expectations" of beneficiaries are protected); *Bailey v. Blue Cross & Blue Shield*, 67 F.3d 53, 57 (4th Cir. 1995) (insured plan; limited abuse of discretion standard applied); *Wheeler v. Dynamic Engineering, Inc.*, 62 F.3d 634, 638 (4th Cir. 1995) (self-funded plan; de novo standard applied); *Lutheran Med. Ctr. v. Contractors Health Plan*, 25 F.3d 616, 621 (8th Cir. 1994) (self-funded plan; abuse of discretion standard applied).

This case and the foregoing authorities demonstrate that the criteria for the application of the doctrine of reasonable expectations in ERISA benefit denial actions are presently at variance and muddled among the courts of appeals. The Ninth Circuit's citation in this case of

Winters v. Costco Wholesale Corp., 49 F.3d 550 (9th Cir.), *cert. denied*, 116 S.Ct. 276 (1995), only compounds this confusion. *Winters* itself involved a *self-funded* medical benefit plan that vested the plan administrator with *discretionary authority* to determine benefit eligibility. However, the Ninth Circuit in *Winters* both recognized and applied the doctrine of reasonable expectations. *Id.* at 555. Thus, the court's holding in this case regarding the inapplicability of the reasonable expectations doctrine is in direct conflict with *Winters*, the authority cited for the holding.

C. Summary of Reasons for Certiorari

The cases cited above, and the Ninth Circuit's decision herein, show present, material conflicts and variance among the courts of appeals regarding the availability of the federal common law doctrine of reasonable expectations as protection to an indisputably large class of benefit plan beneficiaries. Under what was intended to be a uniform federal remedial statute, a plan administrator for a special class of benefit plan in the Ninth Circuit has the discretion to interpret an exclusionary term contained in a SPD against the reasonable expectations of the plan beneficiaries. In other circuits, a plan administrator is denied this discretion. There is an eminent need for uniformity of law on this important matter which this Court can provide.

II. THE DECISION OF THE NINTH CIRCUIT THAT THE FEDERAL COMMON LAW DOCTRINE OF CONTRA PROFERENTEM DOES NOT APPLY IN A SPECIAL CLASS OF BENEFIT DENIAL CASES PRESENTS IMPORTANT QUESTIONS OF FEDERAL LAW THAT HAVE NOT BEEN, BUT SHOULD BE, SETTLED BY THIS COURT

A. The Statutory and Case Law Issues Involved

As discussed above, the custodial care exclusion contained in the 1989 SPD is neither accurate nor written to reasonably apprise the Plan's beneficiaries of the circumstances that would result in denial of their benefits. Instead, the district court found it to be ambiguous and applied contra proferentem to construe the exclusion against the Plan Committee. App. 16-17. The Ninth Circuit implicitly agreed that the custodial care exclusion was ambiguous. App. 1 ("The plan at issue . . . delegates to plan administrators the right to interpret *ambiguous provisions*.") (Emphasis added.) However, the court of appeals held that the federal common law doctrine of contra proferentem did not apply because the Plan was a self-funded, administrator-discretion benefit plan. App. 1-2.

The issues raised are parallel to those discussed above regarding the Ninth Circuit's holding on reasonable expectations. *Firestone* does not hold that the courts must defer to a plan administrator's interpretation of an ambiguous exclusionary provision contained in a SPD. In fact, both the district court (640 F.Supp. at 528-529) and the Third Circuit (828 F.2d at 149-150) expressly found

that Firestone's SPD complied with ERISA's disclosure requirements.

Also, nothing in ERISA or the case law exempts self-funded, administrator-discretion benefit plans from the statute's provisions that require accuracy in SPDs. § 1022(a)(1). However, the Ninth Circuit's decision in this case provides just such an exemption to a plan administrator of a self-funded, administrator-discretion benefit plan. Effectively, under the court's ruling, an administrator has both the discretion to write an ambiguous exclusionary term into a SPD, *and* the discretion to interpret that term against the plan's beneficiaries.

B. The Present Conflicts in the Courts of Appeals

Kunin, supra, decided by the Ninth Circuit in 1990, is often cited as the seminal decision regarding the application of contra proferentem in ERISA benefit denial cases. The court of appeals applied the rule to construe an ambiguous exclusionary medical term against a plan administrator with the following rationale:

> As we noted above, the *contra proferentem* rule is followed in all fifty states and the District of Columbia, and with good reason. Insurance policies are almost always drafted by specialists employed by the insurer. In light of the drafters' expertise and experience, the insurer should be expected to set forth any limitations on its liability clearly enough for a common layperson to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence. Moreover, once the policy language

> has been drafted, it is not usually subject to amendment by the insured, even if he sees an ambiguity; an insurer's practice of forcing the insured to guess and hope regarding the scope of coverage requires that any doubts be resolved in favor of the party who has been placed in such a predicament.

910 F.2d at 540. Although *Kunin* involved an insured benefit plan, the court's rationale is equally applicable to self-funded medical plans. In the instant case it is reasonable to believe that Transamerica had the 1989 SPD drafted by persons specially knowledgeable in such matters. Further, unless the plans are negotiated at arms-length between equal powers[5] (the Plan was not), they are clearly "contracts of adhesion" in so far as the average plan beneficiary is concerned.

The doctrine of contra proferentem has been applied by the federal courts in many ERISA benefit denial cases. However, the rule's present standing among the courts of appeals is far from uniform. The cases are extraordinarily disparate as to both the applicability of the doctrine and the circumstances in which it should apply. The Eighth Circuit has categorically outlawed the application of contra proferentem in ERISA benefit denial actions. *Bernards v. United of Omaha Life Ins. Co.*, 987 F.2d 486, 488 n. 1 (8th Cir. 1993). The application in other circuits is variant. *See, e.g., Collins v. American Cast Iron Pipe Co.*, 105 F.3d 1368, 1371 (11th Cir. 1997) (self-funded plan; standard of review uncertain); *Wahlin, supra*, 78 F.3d at 1235 (7th Cir.

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[5] For example, through collective bargaining. *See Jones v. Laborers Health & Welfare Trust Fund*, 906 F.2d 480, 482 (9th Cir. 1990).

1996) (self-funded plan; abuse of discretion standard applied); *Wheeler, supra,* 62 F.3d at 638 (4th Cir. 1995) (self-funded plan; de novo standard applied); *Nightingale v. Blue Cross,* 41 F.3d 1476, 1481 (11th Cir.), *cert. denied,* 115 S.Ct. 2002 (1995); (self-funded plan; de novo standard applied); *Lee v. Blue Cross/Blue Shield of Alabama,* 10 F.3d 1547, 1551 (11th Cir. 1994) (insured plan; abuse of discretion standard applied); *Doe v. Group Hospitalization & Medical Services,* 3 F.3d 80, 89 (4th Cir. 1993) (insured plan; modified abuse of discretion standard applied); *Heasley v. Belden & Blake Corp.,* 2 F.3d 1249, 1258 (3rd Cir. 1993) (self-funded plan; contra proferentem applied to determine the proper standard of review); *see also Germany v. Operating Engineers Trust Fund,* 789 F.Supp. 1165, 1170 and n. 5 (D.D.C. 1992) (self-funded plan; abuse of discretion standard applied) ("[D]eference to an administrator's interpretation does not trump" the rule of contra proferentem; citing *Kunin, supra,* at 541).

C. Summary of Reasons for Certiorari

Whether contra proferentem is a federal common law doctrine available to resolve an ambiguity in a SPD depends on which court of appeals has jurisdiction over the action. In the Ninth Circuit there is now something akin to a double-deference rule applicable to plan administrators of self-funded, administrator-discretion benefit plans. This rule permits an administrator to take advantage of an ambiguous exclusionary term written by the administrator, regardless of the administrator's failure to meet the accuracy requirements of § 1022(a)(1). In the Seventh Circuit the administrator is prohibited from this compound imprudence. *See Wahlin, supra.*

It is important that this confounded state of the law be addressed and settled by this Court.

III. THE DECISION OF THE NINTH CIRCUIT IN THIS CASE IS INCONSISTENT WITH THE PRINCIPLES OF CONGRESS AND THIS COURT REGARDING THE DEVELOPMENT OF A BODY OF FEDERAL COMMON LAW TO DEAL WITH ISSUES ARISING UNDER ERISA

Congress intended that the courts would develop a body of uniform federal common law to deal with issues involving rights and obligations under employee benefit plans. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987). To fulfill this task the courts have looked to other federal laws which are relevant and analogous to ERISA, as sources for the federal common law. *See, e.g., Donaho v. FMC Corp.*, 74 F.3d 894, 901 (8th Cir. 1996); *Dvorak v. Metropolitan Life Ins. Co.*, 965 F.2d 606, 608-609 (8th Cir. 1992); *Pritt v. UMWA 1950 Ben. Plan and Trust*, 847 F.Supp. 426, 430 and 432 (S.D.W.Va. 1994); *Camelot Care Centers v. Planters Lifesavers Co.*, 836 F.Supp. 545, 548 (N.D. Ill. 1993).

The district court in this case looked to Medicare for assistance in defining "custodial care," an ambiguous exclusionary term not defined in the 1989 SPD. The court's inquiry in this regard was appropriate in that the Plan operated as a Medicare Supplement Plan, paying benefits only secondarily to Medicare.

The district court determined that the Medicare regulations defined custodial care as "'any care that does not meet the requirements for SNF care . . . '" App. 29 and n.

16. This definition was extremely relevant in the instant action because Prudential's claims personnel and the Plan's doctor offered Mrs. Bjurman SNF care in lieu of home health care. App. 30, n. 17. Thus, the court found this determination by the Plan's doctor undermined the Plan Committee's basis for denial of the claims. App. 29-30 and n. 17; App. 35-36. Applying the relevant Medicare regulations to the evidence in the administrative record, the court found as a matter of law that the care prescribed for Mrs. Bjurman was not custodial care. App. 29, n. 16.

Because the custodial care exclusion was not defined in the 1989 SPD, the district court's reference to the Medicare regulations for a relevant definition of custodial care was wholly consistent with the policies of the Congress and this Court expressed above. The resulting conclusion of law reached by the district court should have been regarded by the court of appeals as conclusive evidence of the unreasonableness of the Plan Committee's denial of benefits. This matter also merits review by this Court.

CONCLUSION

For the foregoing reasons, Petitioners respectfully request that this petition be granted.

Dated: July 24, 1997

Respectfully submitted,

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Not for Publication

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

SUSAN A BJURMAN; GEORGE A. BJURMAN, Co-Executors of the Will of Dorothy M. Bjurman,	*	No. 95-56675
Plaintiffs-Appellees,	*	D.C. No. CV-93-04999-RAP(kx)
v.	*	
TRANSAMERICA CORPORATION EMPLOYEES HEALTH CARE PLAN, aka Transamerica Corporation,	*	**MEMORANDUM***
Defendant-Appellant.	*	(Filed Mar. 13, 1997)

Appeal from the United States District Court
for the Central District of California
Richard A. Paez, District Judge, Presiding

Argued and Submitted March 4, 1997
Pasadena, California

Before: **FARRIS, KOZINSKI** and **T.G. NELSON,** Circuit Judges.

The plan at issue is self-funded and expressly delegates to plan administrators the right to interpret ambiguous provisions. The district court therefore improperly

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* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by 9th Cir. R. 36-3.

applied the doctrines of *contra proferentem* and reasonable expectations to the plan's custodial care exclusion. *See Winters v. Costco Wholesale Corp.*, 49 F.3d 550, 553 (9th Cir.), *cert. denied*, 116 S. Ct. 276 (1995). Instead, the district court should have deferred to the plan committee's reasonable interpretation of the provision.

The district court also erred in concluding that the plan committee abused its discretion by denying coverage for Bjurman's 24-hour nursing care. While there was a conflict in the medical evidence presented by the parties, the plan's doctors considered and rejected the medical necessity of around-the-clock care to protect Bjurman against the risk of aspiration and other complications. *E.g.*, ER at 659. We must defer to this reasonable conclusion. *See Barnett v. Kaiser Foundation Health Plan, Inc.*, 32 F.3d 413, 417 (9th Cir. 1994). And we do.

REVERSED and **REMANDED** with instructions to enter summary judgment for appellant. Award of attorney's fees **VACATED.**

Not for Publication

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

SUSAN A BJURMAN; GEORGE A. BJURMAN, Co-Executors of the Will of Dorothy M. Bjurman,	No. 95-56675
Plaintiffs-Appellees,	D.C. No. CV-93-04999-RAP(kx)
v.	
TRANSAMERICA CORPORATION EMPLOYEES HEALTH CARE PLAN, aka Transamerica Corporation,	**ORDER**
Defendant-Appellant.	(Filed Apr. 25, 1997)

Before: **FARRIS, KOZINSKI** and **T.G. NELSON,** Circuit Judges.

The panel has voted to deny the petition for rehearing. The full court has been advised of the suggestion for rehearing en banc and no active judge has requested a vote thereon. Fed. R. App. P. 35(b). The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

SUSAN A. BJURMAN, et al., Plaintiffs, v. TRANSAMERICA CORPORATION EMPLOYEES HEALTH CARE PLAN, Defendant.	CASE NO. CV 93-4999 RAP (Kx) ORDER GRANTING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT (Filed Jun. 8, 1995)

On March 6, 1995, the court heard the parties' cross-motions for summary judgment. After full consideration of the moving, opposition, and reply papers, the evidence submitted by the parties, and the oral arguments of counsel, the court hereby grants plaintiffs' motion for summary judgment. The court finds that there are no genuine issues of material fact and concludes that plaintiffs are entitled to judgment as a matter of law.

Introduction

Plaintiffs Susan A. Bjurman and George A. Bjurman commenced this action in state court on July 22, 1993. On August 20, 1993, defendant Transamerica Corporation ("Transamerica") removed the action to federal court on the basis of federal question jurisdiction. This action

arises under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1101-1461.

Plaintiffs are the surviving children of Mrs. Dorothy Bjurman ("Mrs. Bjurman"), who was a beneficiary under the Transamerica Corporation Employees' Health Care Plan (the "Plan") for retired employees. The Plan is sponsored by Transamerica and, for the relevant time period, was administered by the Prudential Insurance Company of America ("Prudential").

In this action, plaintiffs seek reimbursement from Transamerica[1] for the costs of medically prescribed care which was provided to Mrs. Bjurman before her death.

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[1] The complaint names only Transamerica Corporation as sponsor of the Plan. As Transamerica points out, the sponsor of a plan is not a proper party in an ERISA case. *See Madden v. ITT Long Term Disability Plan*, 914 F.2d 1279, 1287 (9th Cir. 1990), *cert. denied*, 498 U.S. 1087 (1991) (" 'ERISA permits suits to recover benefits only against the Plan as an entity, . . . and suits for breach of fiduciary duty only against the fiduciary.' ").

In their opposition, plaintiffs request leave to file a First Amended Complaint to drop Transamerica Corporation and add the Plan as the proper party. Transamerica opposes this amendment, asserting that the amendment will be futile.

The court finds that the amendment is not futile. As will be discussed below, plaintiffs have proven that they are entitled to relief under ERISA. Further, there is no prejudice in permitting plaintiffs to file the amended complaint because defendant Transamerica has fully defended against this action.

Accordingly, the court grants plaintiffs' request to file the First Amended Complaint naming the Plan as defendant. The First Amended Complaint is deemed filed as of the date it was lodged with the court. Transamerica's answer shall be deemed the Plan's answer to the First Amended Complaint.

The Transamerica Plan Committee (the "Plan Committee") denied coverage for the home care because it determined that the care was primarily custodial and therefore excluded under the Plan's "custodial care" exclusion.

The parties have filed cross-motions for summary judgment. The Plan Committee argues that it is entitled to judgment as a matter of law because the record contains substantial evidence to support the Plan Committee's decision denying Mrs. Bjurman's claim. Plaintiffs, however, contend that the "custodial care" exclusion is ambiguous and that the Plan Committee abused its discretion in construing the "custodial care" exclusion to deny coverage for Mrs. Bjurman's medically prescribed 24-hour home nursing care.

The court agrees with plaintiffs. First, the court finds that the "custodial care" exclusion is ambiguous and that all ambiguities must be construed in favor of coverage. Second, the court finds that the Plan Committee abused its discretion in denying Mrs. Bjurman's claim. Not only did the Plan Committee construe the "custodial care" exclusion in a way that conflicted with the plain language of the Plan but the record also lacks substantial evidence to support the Plan Committee's denial of coverage.

Factual Background

The Plan

Mrs. Bjurman was enrolled in the Plan as a beneficiary of her late husband, George Bjurman. During the relevant period for which plaintiffs seek reimbursement,

Prudential acted as the claims administrator for the Plan, pursuant to a contract with the Plan Committee.[2]

The Plan designates a three-to-seven member committee as Plan "administrator" within the meaning of section 3(16)(A) of ERISA. The Plan Committee has the "authority to control and manage the operation and administration of the Plan as the named fiduciary under section 402(a)(1) of ERISA." *See* Exhibit 1 at 0051.[3]

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[2] Under the Plan, the Transamerica Plan Committee has the authority to "enter into an administrative services only contract with an appropriate service provider for the purpose of providing for the payment of claims and administering benefits under the plan." *See* Exhibit 1, attached to the Administrative Record, at 0052. (Hereafter, citations to exhibits that are attached to the Administrative Record will not include the reference to the "Administrative Record.")

[3] The Plan provides in relevant part:

> The Committee shall have all power necessary to supervise the administration of the Plan and to control its operation in accordance with its terms, including, but not limited by way of limitations, the following powers:
>
> (a) To interpret the provisions of the Plan and to determine any questions arising under, or in connection with the administration or operation of, the Plan;
>
> (b) to determine all considerations affecting the eligibility of any individual to become or remain a Member of the Plan. . . .

See Exhibit 1 at 0051-0052. The Plan further states:

> All decisions of the Committee, and any action taken by it in respect of the Plan and within the powers

Under the "Covered Expense" section, the Plan provides in relevant part:

> Covered expense includes charges for home health care made by a Home Health Agency, provided that the plan of care by the Home Health Agency: (1) Is prescribed by a Doctor; (2) Is reviewed and approved by the Doctor every two weeks; and (3) Contains a statement expressing the belief of the Doctor that the Member's Illness requires medical care and confinement to the home. A copy of this plan of care shall be provided by the Member to the Plan. Home health care includes: (A) Skilled nursing care and home health aide services; and (B) Any other services and supplies provided in lieu of the services which would have been covered under the Plan if the Member was confined in a Hospital or Nursing Home. Home health care does not include housekeeping or custodial care.

See Exhibit 1 at 0103-0104. The Plan further provides: "Covered expense does not include . . . [e]xpense for custodial care, except when provided by a Hospice." *Id.* at 0106.[4]

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granted to it under the Plan, shall be conclusive and binding on all persons. . . .

Id. at 0053.

[4] The Plan defines "hospice care" as "care in a facility recognized by Medicare or by a licensed Home Health Care Agency to provide in-patient support programs or home care services to patients who are at a life-threatening point in a terminal illness." *See* Exhibit 1 at 0016.

In 1989, the provision for home health care coverage under the Plan was amended, providing in relevant part:

> If home health care is prescribed instead of a continued stay in either a hospital or an extended care facility, the Plan will cover home health care at 100% after you have met the annual deductible.
>
> Please note: Home health care must be medically necessary and prescribed by a doctor. It does not include custodial care such as feeding, bathing, or administering medication.

See Exhibit 10 at 0301.

Mrs. Bjurman's Medical Condition

In the last year of her life, Mrs. Bjurman suffered from cancer, strokes and a host of other health-related problems that required 172 days of hospitalization and multiple surgeries. Despite the fact that her doctors prescribed 24-hour home nursing care, Prudential only authorized three visits of skilled nursing care a week.

On February 19, 1992, Mrs. Bjurman underwent her first surgery for rectal cancer. She remained in the hospital for ten weeks, in part, because during the surgery, she suffered a stroke and became partially paralyzed. As a result, the doctors implanted a gastric tube ("g-tube") for feeding. After her release on April 29, 1992, Mrs. Bjurman was hospitalized repeatedly for various medical complications. She underwent a colostomy procedure on May 20, 1992.

Mrs. Bjurman's physicians prescribed 24-hour home nursing care for Mrs. Bjurman and approved a Home

Health Certification and Plan of Treatment. *See* Exhibit 29 at 0417. Because of the "great risk of aspiration pneumonia," the physicians ordered the registered nurses to, among other things, "suction orally/pharyngeal/nasal/deep suctioning [sic]," to insert indwelling catheter as needed for urinary retention and to monitor input and output, and to perform gastric-tube feeding "as instructed and ordered." *See* Exhibit 25 at 0363-64.

On April 29, 1992, plaintiffs hired Stat Medical Services, Inc. ("Stat") to provide the nursing services prescribed by Mrs. Bjurman's physicians. Stat provided 24-hour home nursing care continuously from April 30, 1992, through December 24, 1992.

Prudential's Handling of Mrs. Bjurman's Claim

On May 7, 1992, Stat sought authorization from Prudential for the 24-hour home nursing care. On July 2, 1992, a Prudential case manager authorized temporary weekend nursing care. On July 6, 1992, Ms. Jinell Nichols, the nurse at Prudential who was assigned to handle Mrs. Bjurman's claim, determined that the medically prescribed 24-hour home nursing care was custodial in nature and therefore excluded from coverage. Although the record reveals that Prudential offered a skilled nursing facility ("SNF") to Mrs. Bjurman's daughter, Prudential ultimately only authorized 3 visits by a registered nurse "to assess and do colostomy care." *See* Exhibit 41 at 0489.[5]

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[5] Ms. Nichols notes for July 6, 1992, suggest that Mrs. Bjurman was offered a SNF. *See* Exhibit 33 at 0427. On July 7,

On August 21, 1992, Prudential sent Stat a letter denying coverage under the Plan. Although one of Prudential's nurses may have reviewed some of Stat's nursing notes, there is no evidence that Prudential's medical team ever examined Mrs. Bjurman or contacted any of her doctors before making the final decision to deny coverage under the Plan.

The Appeals Process

On or about September 23, 1992, Mrs. Bjurman's daughter sent a letter to the Plan Committee requesting a review of Prudential's decision denying Mrs. Bjurman's claim for medically prescribed 24-hour home nursing care. On November 23, 1992, a Transamerica Human Resources representative forwarded the appeal to the Transamerica Director of Employee Benefits and recommended payment for the nursing care.[6] The appeal was then referred to the Prudential Regional Appeals Committee. *See* Exhibit 95 at 0644-0645. On December 15, 1992, the Prudential Regional Appeals Committee affirmed Prudential's denial of coverage. *See* Exhibit 102 at 0653. 0658.

1992, Ms. Nichols sent Dr. Small an E-Mail message which stated " . . . daughter refuses SNF. . . . " *See* Exhibit 41 at 0489. Dr. Small's E-mail reply of July 8, 1992, directs Ms. Nichols to "[o]ffer SNF." *See* Exhibit 42 at 0490.

[6] The memorandum states in relevant part: "Based on the seriousness of the medical condition, as stated by the doctors, and the fact that Susan Bjurman has appealed with Prudential, we would recommend that benefit payment be made for the nursing care." Exhibit 83 at 0598.

On December 29, 1992, the Plan Committee considered the Bjurman appeal and reviewed Prudential's decision. After Prudential's representative made a presentation regarding its decision to deny coverage under the Plan, the Plan Committee upheld Prudential's decision. On December 30, 1992, the Plan Committee sent Mrs. Bjurman's daughter a letter denying her appeal and advising her of her right to request further review of the Plan Committee's decision.

On February 21, 1993, Mrs. Bjurman's daughter filed another appeal with the Transamerica Plan Committee. According to the Plan Committee, this appeal raised a "new" issue:

> Mrs. Bjurman required a suction machine at all times. Only an R.N. may perform Endotracheal suctioning. An LVN is not skilled or licensed to do so. Hence, the constant need for a watchful R.N. to be present at all times.

See Exhibit 110 at 0676. On March 30, 1993, the Plan Committee, once again, upheld Prudential's decision to deny coverage under the Plan.

Analysis

A. Standard on Summary Judgment

Rule 56(c) of the Federal Rules of Civil procedure provides for summary judgment if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." *See also Celotex Corporation v. Catrett*, 477 U.S. 317 (1986);

Anderson v. Liberty Lobby, Inc., 477 U.S. 242 (1986); *Matsushita Electrical Industry Co. v. Zenith Radio Corp.*, 475 U.S. 574 (1986). Because there are no genuine issues of material fact in this case, summary judgment is appropriate. *See Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, 46 F.3d 938, 942 (9th Cir. 1995); *Madden v. ITT Long Term Disability Plan*, 914 F.2d 1279, 1283 (9th Cir. 1990).

B. Standard of Review of a Plan Administrator's Decision

The beneficiary of an ERISA plan may bring a civil action against a plan administrator "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, and to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). " '[A] denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.' " *McKenzie v. General Telephone Co.*, 41 F.3d 1310, 1314 (9th Cir. 1994), quoting *Firestone Tire & Rubber Co. v. Brunch*, 489 U.S. 101, 115 (1989). Where the terms of a plan are ambiguous, the court applies a de novo standard of review. *Patterson v. Hughes Aircraft Co.*, 11 F.3d 948, 950 (9th Cir. 1993).

The Plan Committee contends that the abuse of discretion standard applies in this case. Plaintiffs, however, argue that the abuse of discretion standard should not be

applied in this case because a conflict of interest exists and because the terms of the plan are ambiguous.

C. No Conflict of Interest Exists

Courts apply a less deferential standard of review where a conflict of interest exists:

> In *Firestone*, the Supreme Court stated that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion.". . . . Our own cases have interpreted this language to mean that we apply "heightened scrutiny" where the plan administrator has a conflict of interest by virtue of its economic stake in the benefit decision which it makes.

Atwood v. Newmont Gold Co., Inc., 45 F.3d 1317, 1322 (9th Cir. 1995) (citations omitted).

Before the court can apply the "less deferential" abuse of discretion standard, the plaintiff must point to "specific facts" that show that a conflict of interest exists. *Atwood*, 45 F.3d at 1322-1323. As the Ninth Circuit recently stated:

> The "less deferential" standard under which we review apparently conflicted fiduciaries has two steps. First, we must determine whether the affected beneficiary has provided material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's selfinterest [sic] caused a breach of the administrator's fiduciary obligations to the beneficiary. If not, we apply our traditional

> abuse of discretion review. On the other hand, if the beneficiary has made the required showing, the principles of trust law require us to act very skeptically in deferring to the discretion of an administrator who appears to have committed a breach of fiduciary duty.

Id. at 1323.

Plaintiffs have not provided any specific evidence to show that a conflict of interest exists in this case. Plaintiffs simply allege that the members of the Transamerica Plan Committee are all employees of Transamerica and that the Plan is funded partly by Transamerica. These allegations, however, are insufficient to require a less deferential standard of review based on an alleged conflict of interest.

D. The "custodial care" exclusion is ambiguous.

In this case, the Plan provides "100%" coverage for home care that is medically prescribed. The Plan, however, excludes from coverage expenses for "custodial care." Although the term "custodial care" appears various times in the Plan, nowhere is it defined.

Under ERISA, the plan administrator is required to furnish participants of an employee benefit plan with a summary description of the plan ("SPD") that is "written in a manner calculated to be understood by the covered plan participant, and . . . sufficiently accurate and comprehensive to reasonably apprise such participants . . . of their rights and obligations under the plan." 29 U.S.C. § 1022(a)(1). The SPD must describe the "circumstances

which may result in . . . ineligibility, or denial or loss of benefits." 29 U.S.C. § 1022(b).

As the Ninth Circuit recently stated:

> We have interpreted § 1022(b) to mean that the SPD "must be specific enough to enable the ordinary employee to sense when there is a danger that benefits could be lost or diminished.". . . . "The plan's rules should be explained [in the SPD] to permit the ordinary employee to recognize that certain events or action could trigger a loss [or denial] of benefits."

Atwood, 45 F.3d at 1321.

Because the term "custodial care" is not defined in the plan or the SPD, plaintiffs contend that this exclusion is ambiguous as applied to Mrs. Bjurman's case.[7] The

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[7] Plaintiffs also argue that the lack of a definition for "custodial care" renders this exclusion unenforceable. The Eighth Circuit has noted that a plan's failure to define "custodial care" by itself may be a per se violation of ERISA. *Dvorak v. Metropolitan Life Ins. Co.*, 965 F.2d 606 (8th Cir. 1992). The Dvorak Court specifically stated:

> It is disturbing that Metropolitan Life had its own definition of custodial care, as evidenced by Dr. Westbay's testimony, and that the definition appeared nowhere in the Plan. We are troubled with the Plan's failure to define custodial care and, indeed, this may violate ERISA. In view of our determination that the magistrate's finding that Mrs. Dvorak received custodial care was clearly erroneous, however, We need not reach this issue.

965 F.2d at 609. *See also Pritt v. UMWA 1950 Ben. Plan and Trust*, 847 F.Supp. 427, 432, fn.10 (S.D.W.Va. 1994); *Camelot Car Centers*

court agrees with plaintiffs that the "custodial care" exclusion is ambiguous. Although, in most cases, it may be easy to determine what kind of care is custodial, it is not so easy in this case, because the feeding through a g-tube is what, in part, created the medical risk that required 24-hour home nursing care.

An ambiguous term is one that is susceptible of two or more distinct meanings." *Atwood*, 45 F.3d at 1324. The Ninth Circuit has held that if a term limiting coverage in an ERISA plan is ambiguous, the plan administrator must construe such ambiguity in favor of the insured. *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 541 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990).

As the *Kunin* Court explained:

> Insurance policies are almost always drafted by specialists employed by the insurer. In light of the drafters' expertise and experience, the insurer should be expected to set forth any limitations on its liability clearly enough for a common layperson to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence. Moreover, once the policy language has been drafted, it is not usually subject to amendment by the insured, even if he sees an ambiguity; an insurer's practice of forcing the insured to guess and hope

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v. planters Lifesavers Co., 836 F.Supp. 545, 548 (N.D.Ill. 1993). Because the court finds that the term "custodial care" is ambiguous and that the Plan Committee abused its discretion in denying Mrs. Bjurman's claim, the court does not reach the issue of whether the "custodial care" exclusion is unenforceable solely because it was not defined in the plan or the SPD.

> regarding the scope of coverage requires that any doubts be resolved in favor of the party who has been placed in such a predicament.

910 F.2d at 540.[8]

In this case, the "custodial care" exclusion is subject to, at least, two reasonable interpretations when it is applied to Mrs. Bjurman's case. As plaintiffs suggest, the exclusion may mean that only home nursing care that is *not* medically necessary and prescribed by a doctor is custodial, and, therefore, not covered under the Plan. Under this reasonable construction, where a doctor certifies that 24-hour home nursing care is medically necessary, such home care will be covered "100%" under the Plan even though the patient receives some custodial care.

The Plan Committee provides a different interpretation of the "custodial care" exclusion. The Plan Committee argues that the exclusion should be construed to mean that even medically prescribed home nursing care is *not* covered under plan to the extent it requires *any* care which is custodial in nature. Under this construction, if a nurse is involved in feeding or administering medication to a patient, the exclusion applies even though, as here, the medical risk, which makes the 24-hour home care

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[8] The precise issue before the court in *Kunin* was whether the term "mental illness" included autism. The *Kunin* Court concluded that "mental illness" was ambiguous because it was not defined or explained in the plan. The court held that "the failure of the policy to define its terms is fatal to the insurer's attempt to limit payment." 910 F.2d at 541.

medically necessary, is created, in part, by the existence of a g-tube.

Based on these two reasonable interpretations, the court finds that the "custodial care" exclusion is ambiguous and that the *Kunin* rule applies. The court, therefore, must construe the "custodial care" exclusion in Mrs. Bjurman's favor. Because the Plan Committee did *not* construe the ambiguities in the Plan in favor of coverage, the court cannot defer to the Plan Committee's construction of the "custodial care" exclusion to limit payment. *See Kunin*, 910 F.2d at 541.[9]

E. Both Prudential and the Plan Committee abused their discretion in denying coverage for medically prescribed 24-hour home nursing care.

Even if the court applies the abuse of discretion standard, the court finds that both Prudential and the Plan Committee abused their discretion in denying Mrs. Bjurman's claim. Under the abuse of discretion standard, the plan administrator's decision must be upheld unless the plaintiff shows that the administrator's conduct "was arbitrary and capricious." *Barnett v. Kaiser Foundation*

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[9] More recently, the Ninth Circuit limited the applicability of the *Kunin* rule to certain cases. *Winters v. Costco Wholesale Corp.*, 49 F.3d 550 (9th Cir. 1995). In *Winters*, the Ninth Circuit held that "the rule of contra proferentum is not applicable to self-funded ERISA plans that bestow explicit discretionary authority upon an administrator to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 554. The *Winters* limitation, however, does not apply to this case because the Plan is not self-funded.

Health Plan, Inc., 32 F.3d 413, 416 (9th Cir. 1994). As the Ninth Circuit recently stated:

> The touchstone of "arbitrary and capricious" conduct is unreasonableness. "[O]ur inquiry is not into whose interpretation of plan documents is most persuasive, but whether the plan administrator's interpretation is unreasonable."

Id., quoting *Clark v. Washington Teamsters Welfare Trust*, 8 F.3d 1429, 1431 (9th Cir. 1993).

In reviewing a plan administrator's decision under the abuse of discretion standard, the district court can " 'review only the evidence presented to the [plan] trustees.' " *Taft v. Equitable Life Assur. Soc.*, 9 F.3d 1469, 1471 (9th Cir. 1993), quoting *In Jones v. Laborers Health & Welfare Trust Fund*, 906 F.2d 480, 482 (9th Cir. 1990).

Courts have held that "ERISA plan administrators 'abuse their discretion if they render decisions without any explanation, or construe provisions of the plan in a way that conflicts with the plain language of the plan.' " *Taft*, 9 F.3d at 1472, quoting *Eley v. Boeing Co.*, 945 F.2d 276, 279 (9th Cir. 1991). "[A]n administrator also abuses its discretion if it relies on clearly erroneous findings of fact in making benefit determinations." *Taft*, 9 F.3d at 1473.

The plan Committee cautions the court not to make bad law when applying the abuse of discretion standard. While this court recognizes that it must defer to a plan administrator's decision where, as here, the plan gives the administrator the discretion to determine eligibility under the plan, a court cannot simply "rubber stamp" the decision of a plan administrator.

As one district court has so aptly stated:

> "Because ERISA cases frequently touch our human sympathies, court of appeals have cautioned judges to take care, for the general good of the community, that hard cases do not make bad law. That admonishment is not inappropriate. However, it is also true that occasionally 'bad law' makes 'hard cases.' The rules which have evolved concerning the standard of review of the decisions of ERISA fiduciaries are not themselves 'bad law.' However, if courts blindly apply these rules to rubber stamp all decisions made by administrators of ERISA plans, forgetting that those decisions are entitled to deference precisely because of the serious duties imposed upon the plan administrators as fiduciaries, 'bad law' will have developed in practice."

Pritt v. UMWA 1950 Ben. Plan and Trust, 847 F.Supp. 427, 433 (S.D.W.Va. 1994), quoting *Adelson v. GTE Corp.*, 790 F.Supp. 1265, 1274 (D.Md. 1992).

Therefore, under the abuse of discretion standard, deference to a plan administrator's decision is appropriate *only* (1) where the administrators' interpretation of the plan is reasonable and not in conflict with the terms of the plan; and (2) where the decision to deny benefits is "supported by substantial *medical* evidence rendered by qualified medical personnel." *O'Connor v. Central Virginia U.F.C.W.*, 945 F.2d 799, 802 (4th Cir. 1991) (emphasis added).

1. The Plan Committee's Interpretation of the "Custodial Care" Exclusion

While the Transamerica Plan Committee has the discretionary authority to interpret the terms of the Plan, its interpretation cannot conflict with the plain language of the plan. *See Taft*, 9 F.3d at 1472.[10] In the letter denying coverage under the Plan, the Transamerica Plan Committee applied the following definition of "custodial care":

> Custodial care is care provided primarily for the purpose of maintenance, rather than cure, and includes help in walking, feeding, bathing, dressing, administration of medicine which is usually self-administered, or any other care which does not require the specialized skills and training of a licensed medical professional.

See Exhibit 106 at 0669.[11]

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[10] *See also Blau v. Del Monte Corp.*, 748 F.2d 1348, 1354 (9th Cir. 1985) ("With employee welfare benefit plans, . . . imposition of a standard that is not contained in the terms of a plan amounts to an arbitrary and capricious decision."), *cert. denied*, 474 U.S. 865; *Nightingale v. Blue Cross*, 41 F.3d 1476, 1484 (11th Cir. 1995) ("A claims administrator's decision is arbitrary and capricious where new requirements for coverage are added to those enumerated in the plan."), *cert. denied*, ___ U.S. ___, 1995 WL 231156.

[11] In the list of definitions contained in the record and used by Prudential in handling claims, "custodial care" is defined as follows:

> [C]are that provides a level of routine maintenance for the purpose of meeting personal needs. This is care that can be provided by a lay person who does not have professional qualifications, skills or training. Custodial care includes, but is not limited to help in

This definition, however, conflicts with the terms for Plan coverage. Under the Plan, home health care which is "medically necessary and prescribed by a doctor" is covered in full. *See* Exhibit 10 at 30. Therefore, in order for the Plan Committee's construction of the "custodial care" exclusion to be reasonable, it had to incorporate the "medically necessary" standard contained in the Plan. In other words, the "custodial care" exclusion could not be construed in such a way as to exclude medically prescribed and medically necessary care from coverage. To do so would violate the plain language of the Plan and the reasonable expectations of the insureds.

As the record in this case reflects, Mrs. Bjurman's doctors prescribed 24-hour home nursing care because they determined it was medically necessary given her serious medical condition. Simply because a patient

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> walking and getting into or out of bed; help in bathing, dressing, and eating; help in other functions of daily living of a similar nature; administration of or help in using or applying medications, creams and ointments; routine administration of medical gasses after regimen of therapy has been set up; routine care of a patient, including functions such as changes of dressings, diapers, and protective sheets and periodic turning and positioning in bed; routine care and maintenance in connection with casts, braces and other similar devices, or other equipment and supplies used in treatment of a patient, such as colostomy and ileostomy bags including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.

See Exhibit 58 at 0544.

receives some custodial care along with medically prescribed nursing care does not render the treatment custodial and, therefore, excluded from coverage under the Plan. *See Pritt v. UMWA 1950 Ben. Plan and Trust*, 847 F.Supp. 432 (S.D.W.Va. 1994), citing to *Barnett v. Weinberger*, 818 F.2d 953, 969 (D.C.Cir. 1987).

As the Court of Appeals for the District of Columbia in *Barnett* explained:

> To suggest that a victim of a catastrophic illness or a severe accident is receiving "custodial care" simply because the "primary" portion of her attendants' time is spent providing her elemental needs is patently misguided. The critical factor is not the division of percentage of the labor daily received by the patient but the essential nature of the patient's call for supervision and ministration, even if considerably less frequent, from medical professionals.

Id.

Based on the plain language of the Plan, an insured can reasonably expect *full* coverage for 24-hour home nursing care, so long as it is medically prescribed and even if the care includes some custodial care. *See Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382, 386-387 (9th Cir. 1994).[12] Under this construction, coverage for 24-

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[12] In *Saltarelli*, the Ninth Circuit applied the "reasonable expectations" doctrine to ERISA insurance contract interpretation:

> [a]n insurer wishing to avoid liability on a policy purporting to give general or comprehensive coverage must make exclusionary clauses conspicuous, plain,

hour home nursing care that is medically necessary and medically prescribed can only be denied if it is determined that the care is medically unnecessary or unreasonable.[13]

This construction of the "custodial care" exclusion is consistent with the "custodial care" definition included in the 1993 Transamerica SPD. There, "custodial care" is defined as follows:

> [C]are provided *primarily* for the purpose of maintenance, rather than cure. This includes help in walking, bathing, or dressing. It also

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> and clear, placing them in such a fashion as to make obvious their relationship to other policy terms, and must bring such provisions to the attention of the insured.

35 F.3d at 386. The court specifically held that an exclusion for a pre-existing condition was unenforceable because the exclusion was not "clear, plain and conspicuous enough to negate" a layperson's "objectively reasonable expectations of coverage." *Id.* at 387. Here, the "custodial care" exclusion was not clear enough to negate Mrs. Bjurman's reasonable expectations that medically prescribed and medically necessary care would be covered under the Plan.

[13] Plaintiffs point to a document which is not part of the administrative record which they claim further supports their position that a nurse is required to feed a patient that has a G-tube. This document is a memo that states that, after discussing the issue with a prudential doctor, "it has been determined that G-tube feeding requires skilled nursing care." *See* Declaration of Hugh E. Knowlton ("Knowlton Decl.") at ¶ 8; Exhibit 9, attached to Knowlton Decl. Here, Mrs. Bjurman had a g-tube implanted after her first operation. Therefore, even under Prudential's own guidelines, a nurse was required to feed and provide medications to Mrs. Bjurman.

> includes preparing foods or special diets, feeding, the administration of medicine which is usually self-administered or any care that does not require the assistance of a licensed medical professional.

See Exhibit 2 at 0217 (emphasis added).

Under this definition, the "custodial care" exclusion applies only if the 24-hour home care is provided *primarily* for maintenance. However, where, as here, the home care is medically prescribed *primarily* for therapeutic or medical reasons, the "custodial care" exclusion does *not* apply.[14] Therefore, because the Plan Committee ignored the "medically necessary and prescribed by a doctor" language in construing the "custodial care" exclusion, the Plan Committee abused its discretion.

2. The Plan Committee's Decision to Deny Coverage

Plaintiffs contend that the record lacks substantial *medical* evidence to support the decision to deny coverage

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[14] *See Coe v. Secretary of H.E.W.*, 502 F.2d 1337, 1340 (4th Cir. 1974). In *Coe*, the Fourth Circuit consulted Webster's Dictionary to construe the term "custodial" under the Medicare Act. Webster's Dictionary defines "custodial" as "marked by or given to watching and protecting rather than seeking to cure." *Id.* The court reversed the district court's affirmance of the denial of a claim for nursing home benefits as being custodial. The court stated: "Exclusions from coverage should be narrowly construed lest they inadvertently encompass the qualifications for benefits. Thus, when an elderly person needs both custodial and skilled nursing care, the remedial purpose of the Act would be defeated by denying coverage." *Id.*

for Mrs. Bjurman's medically prescribed 24-hour home nursing care. The Plan Committee responds that Prudential and the Plan Committee did not abuse their discretion in determining that the medically prescribed nursing care was not covered under the Plan. The court finds that the record does not support the Plan Committee's position.

Mrs. Bjurman's doctors issued Home Health Certifications and Plans of Treatment requiring 24-hour home nursing care and stressed repeatedly to Prudential the need for such care given Mrs. Bjurman's serious medical condition.[15] After the Prudential case manager made the initial decision to deny Mrs. Bjurman's claim, Mrs. Bjurman's physicians wrote to Prudential informing its medical team that there was (1) a risk of aspiration due to dysphagia; (2) a risk of dehydration due to unstable bowel functions; and (3) a risk of malnutrition because she could not take foods by mouth. *See* Exhibit 65 at 0567.

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[15] After her surgery for rectal cancer, Mrs. Bjurman's physicians instructed the nurses to perform the following tasks and procedures: monitor her cardio-pulmonary status; "be alert to signs of aspiration pneumonia"; suction as needed; monitor her temperature and vital signs; assess her skin condition to prevent bed sores and apply ointment; assess the frequency of diarrhea and medicate as needed; assess the character and consistency of her stools and inform physician of any indications of rectal bleeding or continuous diarrhea; assess her tolerance to gastric-tube feeding, use kangaroo pump if necessary and assess the position of her gastric tube; assist with "all transfers and ambulation as instructed by Physical Therapist"; monitor and assess turgor to prevent dehydration; and "feed patient orally with maximum of 1 can . . . pudding." Exhibit 29 at 0417-0418.

Prudential, however, rejected Mrs. Bjurman's doctors' expert medical opinions without providing any specific reasons. The record simply contains E-mail messages by members of the Prudential team to each other concluding that 24-hour nursing care was custodial and that only three visits by a registered nurse a week was medically necessary. Even after closely examining the record, the court cannot determine how the Prudential team arrived at their decision to deny coverage for the medically prescribed 24-hour home nursing care.

Although the Plan Committee asserts that the Prudential team independently evaluated Mrs. Bjurman's claim, there is no evidence in the record which shows that Prudential or the Plan Committee consulted with Mrs. Bjurman's doctors to determine whether the prescribed nursing care was medically necessary. Before denying coverage, the Plan Committee had an obligation to, at the very least, determine whether the expert opinions of Mrs. Bjurman's doctors were medically reasonable.

Further, the letter from the Transamerica Plan Committee denying coverage under the plan simply states that the care provided to Mrs. Bjurman was custodial in nature. *See* Exhibit 106 at 0669-0671. The Plan Committee simply disregarded the fact that Mrs. Bjurman's doctors had determined that the 24-hour home nursing care was *medically* necessary.

The August 21, 1992 denial letter from Prudential states in relevant part: "To be consider [sic] reasonably necessary, the service or supply must be commonly and customarily recognized throughout the physician's profession as appropriate in the treatment of the patient's

diagnosed sickness or injury. The service or supply must not be educational or experimental in nature, nor provided primarily for the purpose of medical or other research." *See* Exhibit 73 at 0586. There is no evidence in the record to show that the 24-hour home nursing care was unreasonable or that the care was prescribed for educational, experimental or research purposes.

Therefore, even under the Plan Committee's criteria, the care prescribed to Mrs. Bjurman was medically reasonable and therefore covered under the Plan. In fact, one of Prudential's own doctors recommended that a skilled nursing facility ("SNF") be offered in Mrs. Bjurman's case. *See* Exhibit 83 at 0599.[16] The fact that one of Prudential's doctors determined that SNF care was appropriate

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[16] SNF is most commonly associated with the Medicare Act, which provides, in relevant part, that "custodial care is any care that does not meet the requirements for coverage as SNF care as set forth in §§ 409.30 through 409.33 of this chapter." 42 C.F.R. § 411.15. Although the statute does not define the "custodial care" term, regulations have been promulgated to provide criteria in determining when care is custodial. The regulations exclude from the "custodial care" definition care that is "necessary for the management of terminal illness." *See* 42 C.F.R. §§ 411.15, 409.33. "Skilled nursing" services include the "development, management, and evaluation of a patient care plan based on the physician's orders" and the "[o]bservation and assessment of the patient's changing condition." 42 C.F.R. § 409.33. Procedures that require "skilled nursing" include "[l]even tube and gastrostomy feedings; . . . [n]asopharyngeal and tracheostomy aspiration; . . . [i]nsertion and sterile irrigation and replacement of catheters; . . . [and a]pplication of dressings involving prescription medications and aseptic techniques." *Id.* The court finds that, based on the Medicare regulations, the 24 hour-care prescribed by Mrs. Bjurman's doctors was not "custodial" in nature.

undermines the Plan Committee's position that Prudential's decision is supported by the record.[17]

The only medical evidence which the Plan Committee can point to in the record to support its decision to deny coverage is Stat's nursing notes for the care provided to Mrs. Bjurman. According to the Plan Committee, the nursing notes reveal that Mrs. Bjurman never received deep suctioning and that she never suffered from aspiration. The Plan Committee suggests that, based on this evidence, the risk of aspiration was not real and, therefore, the care prescribed by her doctors was not medically necessary nor reasonable.

However, the Plan Committee can point to *no* medical evidence in the record which existed at the time that Mrs. Bjurman was being cared for to contradict or dispute the expert opinions of Mrs. Bjurman's treating physicians. Neither the Plan Committee nor Prudential conducted any independent medical investigation or evaluation of Mrs. Bjurman's condition. There is no evidence that Mrs. Bjurman's doctors were ever consulted by the Plan Committee before denying coverage. In fact, it appears that Prudential and the Plan Committee reviewed the nursing notes only *after* making their decision to deny coverage. The nursing notes, while relevant, cannot be used by the

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[17] The Plan Committee attempts to argue that SNF was never offered. The record, however, evidences that Prudential's doctors and nurses offered SNF care to Mrs. Bjurman. As one Prudential administrator noted, "Dr. Small offered SNF care – mistake – implies approval of need for 24 [hour] nursing. *See* Exhibit 104 at 0660.

Plan Committee, after the fact, to second-guess and question Mrs. Bjurman's doctors and to justify its decision to deny coverage under the Plan.

Based on the lack of "substantial" medical evidence in the record to support the Plan Committee's decision, the court finds that the Plan Committee abused its discretion in denying coverage for Mrs. Bjurman's medically prescribed and medically necessary 24-hour home care under the "custodial care" exclusion.

F. Plaintiff's Recovery

The only question remaining in this case is whether plaintiffs are entitled to recover the full cost of the 24 hour home nursing care actually provided to Mrs. Bjurman. Normally, the court would remand the action to the plan administrator to make the necessary factual findings. *See Patterson,* 11 F.3d at 951. However, remand is not necessary in this case. Having found that the "custodial care" exclusion was ambiguous and that the Plan Committee abused its discretion in denying coverage under its Plan, the court is in as good a position as the Plan Committee to determine whether the 24-hour home nursing care is covered in full under the Plan.

As discussed above, home health care that is "medically necessary and prescribed by a doctor" is covered "100%" under the Plan. It is undisputed that Mrs. Bjurman's 24-hour home nursing care was prescribed by her doctors as medically necessary. There is no evidence in the record to suggest that the 24-hour home nursing care was medically unreasonable. Under these circumstances,

the court finds that Mrs. Bjurman's care is covered in full under the Plan.

Conclusion

As set forth above, plaintiffs' motion for summary judgment is hereby granted. Judgment in favor of the plaintiffs against the plan shall be entered forthwith.

IT IS SO ORDERED.

DATED: June 7, 1995.

RICHARD A. PAEZ
Richard A. Paez
United States District Judge

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

SUSAN A. BJURMAN, et. al. Plaintiffs, v. TRANSAMERICA CORPORATION EMPLOYEES HEALTH CARE PLAN, Defendant.	CASE NO. CV 93-4999 RAP (Kx) ORDER AMENDING JUDGMENT TO CORRECT CLERICAL ERROR AND TO AWARD PREJUDGMENT INTEREST; ORDER AWARDING PLAINTIFFS REASONABLE ATTORNEY'S FEES (Filed Sept. 28, 1995)

INTRODUCTION

This action arises under the Employment Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1101-1461. The plaintiffs are the surviving children of Mrs. Dorothy Bjurman, who was a beneficiary under the Transamerica Corporation Employees' Health Care Plan (the "Plan") for retired employees. The Plan was sponsored by defendant, Transamerica Corporation ("Transamerica"), and administered by the Prudential Insurance Company of America ("Prudential"). Plaintiffs alleged in their complaint that the denial of coverage for Mrs. Bjurman's 24-hour nursing care violated the terms of the Plan.

The parties filed cross-motions for summary judgment on January 10, 1995. On March 6, 1995, the court heard both motions. After oral argument, the court took

the matters under submission. The court filed its order granting plaintiffs' motion for summary judgment on June 8, 1995. The court found that the "custodial care" exclusion was ambiguous and that this ambiguity had to be construed in favor of the insured. The court, alternatively, found that the Plan Committee abused its discretion in denying Mrs. Bjurman's claim. The record revealed not only that the "custodial care" exclusion was interpreted in a way that conflicted with the plain language of the Plan, but also, that the Plan Committee's decision to deny coverage in this case was not supported by substantial evidence.

On July 10, 1995, plaintiffs filed motions to: (1) correct a clerical error in the order granting plaintiffs' motion for summary judgment under Rule 60(a); (2) amend the judgment to award prejudgment interest under Rule 59(e); and (3) award reasonable attorneys' fees and costs under 29 U.S.C. § 1132(g)(1).

On August 7, 1995, the court heard plaintiffs' motions. Defendants did not oppose plaintiffs' motion to correct the clerical error. As to the other motions, the court indicated that it was inclined to award prejudgment interest and reasonable attorneys' fees and costs. The court submitted the matters to decide the appropriate amount of plaintiffs' attorney fee award.

After full consideration of the moving, opposition, and reply papers, the oral arguments of counsel, and all other matters presented to the court, plaintiffs' motions are hereby granted as follows:

1. The court's June 8, 1995 order granting plaintiffs' motion for summary judgment is amended to correct the clerical error identified by plaintiffs;

2. The court amends the judgment to award pre-judgment interest to plaintiffs pursuant to Rule 59(e); and

3. The court awards plaintiffs reasonable attorney's fees and costs. Further, this order shall constitute the court's findings of fact and conclusions of law as required by Rule 54(d)(2)(c).

DISCUSSION

A. Clerical Error

A court may correct an order pursuant to Rule 60(a), so long as the correction is intended to conform the order to the original intent of the court. Rule 60(a) provides in relevant part:

> Clerical mistakes in . . . orders . . . arising from oversight or omission may be corrected by the court at any time of its own initiative or on the motion of any party and after such notice, if any, as the court orders.

Further, the Ninth Circuit has explained:

> The basic distinction between 'clerical mistakes' and mistakes that cannot be corrected pursuant to Rule 60(a) is that the former consists of 'blunders in execution' whereas the latter consist of instances where the court changes its mind . . .

Harman v. Harper, 7 F.3d 1455, 1457 (9th Cir. 1993).

Here, plaintiffs request that a clerical mistake in the court's order should be amended as follows:

> *Page 23, footnote 17, lines 27-271/2:* The reference to "one Prudential administrator" is incorrect. The subject note was made by Ms. Diane Berry, an employee of Transamerica Corporation and a member and secretary of the Plan Committee. *See* B Deposition 5:6-14, 15:25-17:2. Plaintiffs request that the subject phrase be corrected to read: "As one member of the Plan Committee noted, . . . "

The Court's use of the phrase "one Prudential Administrator" was an oversight and should be corrected as requested by plaintiffs. Accordingly, pursuant to Rule 60(a), the court orders that the June 8, 1995 order be amended to correct this clerical error.

B. Prejudgment Interest

1. Standard for prejudgment interest

Federal Rule of Civil Procedure 59(e) states that a motion "to alter or amend the judgment shall be served no later than 10 days after entry of the judgment." If the court determines that the motion to amend or alter the judgment was served timely, then the court has the discretion to award prejudgment interest. *See Katsaros v. Cody*, 744 F.2d 270, 281 (2d Cir. 1984), *cert. denied*, 469 U.S. 1072 (1984). Here, plaintiffs' motion to amend the judgment was filed timely.

In deciding whether to award prejudgment interest in an ERISA case, the Eight Circuit has held that "[a]n award of prejudgment interest is necessary to allow a prevailing ERISA beneficiary to obtain 'appropriate equitable relief.' " *Lutheran Medical Center v. Contractors,*

Laborers' Teamsters and Engineers Health and Welfare Plan, 25F.3d 616, 623 (8th Cir. 1994). "Generally, a court should award prejudgment interest unless 'exceptional or unusual circumstances exist making the award of interest inequitable.' " *Id.*, quoting *Stroh Container Co. v. Delphi Indus., Inc.*, 783 F.2d 743, 752 (8th Cir.), *cert. denied*, 476 U.S. 1141 (1986).

Here, there are no unusual circumstances which would warrant the denial of an award of prejudgment interest in this case. Plaintiffs were denied the use of Mrs. Bjurman Plan benefits and had to rely on their own funds to pay for her medical care. An award of prejudgment interest compensates plaintiffs for the benefits Mrs. Bjurman would have received had the Plan Committee authorized the payment of her 24 hour home nursing care, which the court determined *was* covered under the Plan.

In setting the rate of prejudgment interest, the Ninth Circuit has held:

> The proper interest rate is that established by 28 U.S.C. § 1961. The measure of interest rate prescribed for postjudgment interest in 28 U.S.C. § 1961 is also appropriate for fixing the rate for pre-judgment interest unless the equities of a particular case demand a different rate.

In Re Glacier Bay, 746 F.Supp. 1379, 1395 (D.Alaska 1990), *quoting Columbia Brick Works Inc. v. Royal Insurance Co. of America*, 768 F.2d 1066, 1071 (9th Cir. 1985). *See also Blanton v. Anzalone*, 813 F.2d 1574, 1576-1577 (9th Cir. 1987).

Section 1961(a) provides in relevant part:

> Interest shall be allowed on any money judgment in a civil case recovered in a district court

> . . . . Such interest shall be calculated from the date of the entry of the judgment, at a rate equal to the coupon issue yield equivalent . . . of the average accepted auction price for the last auction of fifty-two week United States Treasury Bills settled immediately prior to the date of the judgment.

Accordingly, plaintiffs are entitled to an award of prejudgment interest at the Treasury Bill rate set forth in § 1961(a) from March 30, 1993, the date The Plan Committee denied plaintiffs' claim, to the date of entry of the amended judgment. The judgment shall be amended accordingly. Plaintiffs are also entitled to interest on the judgment as provided by 28 U.S.C. § 1961.

C. Reasonable Attorneys' Fees and Costs.

1. Standard for an award of reasonable attorneys' fees and costs

ERISA provides that in an action "by [a] participant, beneficiary, or fiduciary, the court in its discretion may allow reasonable attorneys' fees and costs of action to either party." 29 U.S.C. § 1132(g)(1). "As a general rule, ERISA employee plaintiffs should be entitled to a reasonable attorney's fees if they succeed on any significant issue in litigation which achieves some of the benefit the parties sought in bringing the suit." *Nelson v. EG & G Energy Measurements Group, Inc.*, 37 F.3d 1384, 1392 (9th Cir. 1985), quoting *Smith v. CMTA-IAM Pension Trust*, 746 F.2d 587, 589 (9th Cir. 1985). As the Ninth Circuit has stated, section 1132(g)(1) "should be read broadly to mean that a plan participant or beneficiary, if he prevails in his suit under § 1132 to enforce his rights under the

plan, should ordinarily recover an attorney's fee unless special circumstances would render such an award unjust." *Id.*

2. The *Hummell* Factors

In awarding attorneys' fees under ERISA, courts consider the following factors:

> (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of fees; (3) whether an award of fees against the opposing parties would deter others from acting under similar circumstances; (4) whether the parties requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA; and (5) the relative merits of the parties' positions.

Saltarelli v. Bob Baker Group Medical Trust, 35 F.3d 382, 388 (9th Cir. 1994), quoting *Hummell v. S.E. Rykoff & Co.*, 634 F.2d 446, 453 (9th Cir. 1980).

"No one of the *Hummell* factors, however, is necessarily decisive, and some may not be pertinent in a given case." *Smith v. CMTA-IAM Pension Trust*, 746 F.2d 587, 590 (9th Cir. 1984). In deciding on award fees, the district court "should apply discretion consistent with the purpose of ERISA, those purposes being to protect employee rights and to secure effective access to federal courts." *Nelson*, 37 F.3d at 1392.

Defendant contends that plaintiffs are not entitled to attorney's fees, because they have not satisfied any of the

Hummell factors. The court disagrees. As will be discussed more fully below, the *Hummell* factors weigh in favor of an award of reasonable attorney's fees and costs in this case.

a. The degree of opposing parties' culpability and bad faith.

Defendant argues that in the absence of bad faith the court should decline to further punish the losing defendant with an award of attorney's fees. The Ninth Circuit has stated that "[a]lthough bad faith is a factor that would always justify an award, it is not required." *Smith*, 746 F.2d at 590. And, although the record in this case may not be sufficient to show bad faith, the court did find that the Plan Committee had abused its discretion in denying coverage of Mrs. Bjurman's 24-hour home nursing care. Such culpable conduct is sufficient to support an award of attorney's fees.

b. The Ability of the Plan to Satisfy the Award

Defendant contends the plaintiffs' request should be denied because plaintiffs have failed to provide evidence that the Plan can satisfy the award. Plaintiffs assert that the Plan has the ability to satisfy the award and point to Ms. Berry's deposition transcript which states the Plan's funds exceed $40 million. B ¶ 5, Exhibit 61. Because Ms. Berry's testimony is uncontradicted, the court finds that the plan can satisfy the award.

Further, as the Ninth Circuit has stated:

> "Not to award fees in cases such as this would be tantamount to repealing the Act itself by frustrating its basic purpose. It is difficult for individual members . . . to stand up and fight those who are in charge. . . . Without counsel fees the grant of federal jurisdiction is but a gesture for few . . . [plan] members could avail themselves of it.

Smith, 746 F.2d at 590, *quoting Hall v. Cole*, 412 U.S. 1, 13, 93 S.Ct. 1943, 1950 (1973).

c. Whether an award would deter the Plan or other from acting similarly in the future

The defendant claims that awarding fees would chill proper plan interpretation and application. However, awarding fees in this case will serve to deter the arbitrary denial of claims. A fee award will ensure that all decisions of the Plan Committee are supported by substantial evidence.

d. Whether plaintiff sought to benefit all participants

The defendant asserts that plaintiffs' lawsuits did not seek to benefit any other participants. While it is true that plaintiffs' action was individual in nature, the court's decision interpreted an exclusion which no doubt may arise in other case. As a result, plaintiffs' action will have an indirect benefit on Plan participants and beneficiaries.

e. The relative merits of the parties positions

Defendant repeatedly stresses that there was a "bona fide dispute" between the parties and that the court applied the law incorrectly. Not only are these arguments more properly raised on a motion for reconsideration or on appeal but, more importantly, these arguments do not accurately reflect the court's holding in this case. In addition to concluding that the "custodial care" exclusion was ambiguous, the court alternatively found that the Plan Committee had abused its discretion in denying Mrs. Bjurman's claim. Because the Plan abused its discretion, defendant's position was without merit.

3. The amount of the fee award

Having determined that the plaintiffs are entitled to attorney's fees, the court must now determine the actual amount it will award plaintiffs. The Ninth Circuit has adopted the "lodestar/multiplier" approach in setting the amount of fees in ERISA cases. As the Supreme Court explained in *Hensley v. Eckerhart*, 461 U.S. 424, 433, 103 S.Ct. 1933, 1939 (1983), the "lodestar/multiplier" approach is a two-part test:

> First, the court must determine a "lodestar" amount by multiplying the number of hours reasonably expended on the litigation by a reasonable hourly rate. . . . Second, the court may increase or decrease the lodestar fee based on factors identified by this circuit in *Kerr v. Screen Extras Guild, Inc*, 526 F.2d 67, 70 (9th Cir. 1975), *cert. denied*, 425 U.S. 951, 96 S.Ct. 1726, 48 L.Ed.2d 195 (1976), that are not subsumed

> within the initial calculation of the lodestar. . . . Such upward or downward adjustments are the exception rather than the rule since the lodestar amount is presumed to constitute a reasonable fee.

D'Emanuele v. Montgomery Ward & Co., 904 F.2d 1379, 1382-1383 (9th Cir. 1990).

The Ninth Circuit in *D'Emanuele* summarized the *Kerr* factors as follows:

> (1) the time and labor required, (2) the novelty and difficulty of the question involved, (3) the skill requisite to perform the legal service properly, (4) the preclusion of other employment by the attorney due to acceptance of the case, (5) the customary fees, (6) whether the fee is fixed or contingent, (7) time limitations imposed by the client or the circumstances, (8) the amount involved and the results obtained, (9) the experience, reputation, and the ability of the attorneys, (10) the "undesirability" of the case, (11) the nature and length of the professional relationship with the client, and (12) awards in similar cases.

904 F.2d at 1383.

a. The Lodestar Amount

In order to calculate the lodestar amount, the court must determine the reasonable amount of hours expended on the case and multiply this amount by a reasonable hourly rate. As the Ninth Circuit has explained:

> The district court should exclude from this initial calculation hours that were not "reasonably expended." Case may be overstaffed, and the skill and experience of lawyers vary widely.

D'Emanuele, 904 F.2d at 1384, *quoting Hensley*, 461 U.S. at 434, 103 S.Ct. at 1939.

According to the declarations submitted by plaintiffs, plaintiffs' counsel spent 482.30 hours working on this lawsuit. Defendant contends that almost half of these hours are excessive. According to defendant, the court should deduct the following hours as unreasonable:

Category	Hours
1. Administrative proceeding	17
2. Excessive legal research	43
3. Excessive Factual investigation	110
4. Excessive time on summary judgment	40
5. Excessive time on communication	31
TOTAL	241

Reducing plaintiffs' hours by 50% is unreasonable. Plaintiffs obtained excellent results and have properly documented their fee request. Although the court was limited to the administrative record, plaintiffs should not be penalized for pursuing various legal theories and for conducting a thorough investigation of the facts. The issues raised in this case were complicated. Further, the administrative record was voluminous. Under these circumstances, plaintiffs are entitled to be compensated for all fees reasonably expended in litigating their case.

As the Supreme Court in *Hensley*, 461 U.S. at 424, 103 S.Ct. at 1940, stated:

> Where a plaintiff has obtained excellent results, his attorney should recover a fully compensatory fee. Normally this will encompass all hours reasonably expended on the litigation, and indeed in some case of exceptional success an enhanced award may be justified. In these circumstances, the fee award should not be reduced simply because the plaintiff failed to prevail on every contention raised in the lawsuit. . . . Litigants in good faith may raise alternative legal grounds for a desired outcome, and the court's rejection of or failure to reach certain grounds is not a sufficient reason for reducing a fee. The result is what matters.

However, compensating plaintiffs for all the hours spent by plaintiffs' counsel to gain an understanding of basic principles of ERISA law is unreasonable. Because plaintiffs' counsel had never handled an ERISA case, he should have exercised billing judgment and deducted some of his hours from the fee request. As the Supreme Court has stated:

> Cases may be overstaffed, and the skill and experience of lawyers vary widely. Counsel for the prevailing party should make a good-faith effort to exclude from a fee request hours that are excessive, redundant, or otherwise unnecessary, just as a lawyer in private practice ethically is obligated to exclude such hours from his fee submission. "In the private sector, 'billing judgment' is an important component in fee setting. It is no less important here. Hours that are not properly billed to one's *client* also are not properly billed to one's *adversary* pursuant to statutory authority."

Hensley, 461 U.S. at 424, 103 S.Ct. at 1939-1940, citations omitted (emphasis in original).

Because plaintiffs' attorney did not exercise appropriate billing judgment, the court reduces plaintiffs' attorney hours by 10%. Plaintiffs are entitled to be compensated for 434 hours at a reasonable rate of $285.00 per hour. In addition, plaintiffs are entitled to recover their out of pocket expenses as part of their attorney's fee award that would not otherwise be recoverable as costs under Rule 50(d)(1). See *Davis v. City and County of San Francisco,* 976 F.2d 1536, 1556 (9th Cir. 1992); *Sneede By Thompson v. Coye,* 856 F.Supp. 526, 536 (N.D.Cal. 1994). The $2,212.27 in out of pocket expenses and costs claimed by plaintiffs in this motion are reasonable and necessary. Thus, plaintiffs are awarded $125,902.27 in attorney's fees and out of pocket expenses.

b. The multiplier

Having determined the lodestar amount, the next step is to determine whether a multiplier should be applied to plaintiffs award. Plaintiffs have requested an enhancement of their award by 25%.

Upward and downward adjustments in a fee award are the exception. As the Ninth Circuit stated in *D'Emanuele:*

> There is a strong presumption that the lodestar figure . . . represents a "reasonable" attorney's fee. . . . Nevertheless, in certain "rare exceptional cases" the lodestar figure may be adjusted upward or downward in consideration of the

> *Kerr* factors that are not subsumed [in the lodestar computation]. "[W]e will give courts latitude to balance and weigh permissible factors" although "reliance on factors . . . subsumed in the lodestar determination will be considered an abuse of the trial court's discretion."

904 F.2d at 1384.

However, any *Kerr* factors which are subsumed in the initial lodestar calculation cannot be considered in deciding whether to apply the multiplier. *See D'Emanuele*, 904 F.2d at 1386. Here, the lodestar calculation takes into account all of the applicable *Kerr* factors. Plaintiffs cannot point to any factor which is not subsumed in the lodestar calculation which would warrant an enhancement of their award. Accordingly, the court denies plaintiffs' request for an enhancement of their fee award.

CONCLUSIONS

As set forth above, the court grants plaintiffs' motions and orders the following:

1. The reference to the "one Prudential administrator" on page 23 of the court's June 8, 1995 order is corrected to read "As one member of the Plan Committee noted";

2. Plaintiffs are entitled to prejudgment interest at the Treasury Bill rate set forth in § 1961(a) from March 30, 1993, to the date of the entry of an amended judgment;

3. Plaintiffs are entitled to reasonable attorney's fees and out of pocket expenses in the amount of $125,902.27.

It is further ordered that a separate judgment be entered on the attorney's fee award.

IT IS SO ORDERED.

DATED: September 27, 1995.

/s/ Richard A. Paez
Richard A. Paez
United States
District Judge

STATUTES AND REGULATIONS

Title 29, United States Code:

§ 1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; . . . that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans. . . .

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries,

by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

. . .

§ 1002. Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness. . . .

. . .

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

. . .

(8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee

benefit plan, who is or may become entitled to a benefit thereunder.

§ 1003. Coverage

(a) Except as provided in subsection (b) of this section and in sections 1051, 1081, and 1101 of this title, this subchapter shall apply to any employee benefit plan if it is established or maintained –

> (1) by any employer engaged in commerce or in any industry or activity affecting commerce. . . .

§ 1021. Duty of disclosure and reporting

(a) Summary plan description and information to be furnished to participants and beneficiaries

The administrator of each employee benefit plan shall cause to be furnished in accordance with section 1024(b) of this title to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan –

> (1) a summary plan description described in section 1022(a)(1) of this title. . . .

§ 1022. Plan description and summary plan description

(a)(1) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information

described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

. . .

(b) The . . . summary plan description shall contain the following information: . . . circumstances which may result in disqualification, ineligibility, or denial or loss of benefits. . . .

§ 1024. Filing and furnishing of information

. . .

(b) Publication of summary plan description . . . to participants and beneficiaries of plan

Publication of the summary plan descriptions . . . shall be made to participants and beneficiaries of the particular plan as follows:

(1) The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of the summary plan description, and all modifications and changes referred to in section 1022(a)(1) of this title –

. . .

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought –

(1) by a participant or beneficiary –

. . .

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

. . .

(e) Jurisdiction

(1) . . . State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

Title 29, Code of Federal Regulations:

§ 2520.102-2 Style and format of summary plan description.

(a) *Method of presentation.* The summary plan description shall be written in a manner calculated to be understood by the average plan participant and shall be sufficiently comprehensive to apprise the plan's participants and beneficiaries of their rights and obligations under the plan. In fulfilling these requirements, the plan administrator shall exercise considered judgment and discretion by taking into account such factors as the level

of comprehension and education of typical participants in the plan and the complexity of the terms of the plan. Consideration of these factors will usually require the limitation or elimination of technical jargon and of long, complex sentences, the use of clarifying examples and illustrations, the use of clear cross references and a table of contents.

. . .

Supreme Court, U.S.
FILED
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No. 97-167

In The

Supreme Court of the United States

October Term, 1997

SUSAN A. BJURMAN and GEORGE A. BJURMAN,
Co-Executors of the Will of Dorothy M. Bjurman,

Petitioners,

vs.

TRANSAMERICA CORPORATION EMPLOYEES
HEALTH CARE PLAN,

Respondent.

**On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit**

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the court of appeals, applying settled legal principles to its review of a detailed administrative record, properly held that it should defer to an ERISA plan administrator's reasonable conclusion, supported by substantial medical evidence, that 24-hour home nursing care was not covered by the plan.

2. Whether the court of appeals properly held that the insurance doctrines of *contra proferentem* and "reasonable expectations" are inapplicable to review of a plan administrator's interpretation of a self-funded ERISA plan where the plan expressly delegates to the administrator the right to interpret ambiguous plan provisions.

CORPORATE DISCLOSURE PURSUANT TO RULE 29.6

Respondent Transamerica Corporation Employees Health Care Plan (the "Plan") is not a corporation. However, Transamerica Corporation, the Plan Administrator and the company whose employees are beneficiaries of the Plan, is a corporation. It has no parent company and no nonwholly owned direct subsidiaries.

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STATEMENT OF THE CASE

I. NATURE OF THE CASE AND THE PROCEEDINGS BELOW

This case involved a claim by petitioners that an ERISA-governed health care plan (the "Plan") should have paid for seven months of 24-hour-a-day, seven-days-a-week nursing care petitioners had ordered for their mother, Dorothy Bjurman. From the outset, petitioners were advised by the claims administrator for the Plan that the Plan would not cover that part of the around-the-clock expense that was custodial care because the Plan covered only home health care that was "medically necessary." Petitioners ordered the 24-hour care anyway and appealed the partial denial of coverage to the Plan Administrator.

Relying on the opinions of five independent medical professionals, detailed nursing notes and other substantial medical evidence, the Plan Administrator determined that three nursing visits per week were sufficient to meet Mrs. Bjurman's "medically necessary" needs and that the additional care ordered by petitioners was not "medically necessary" (an express requirement for Plan coverage) and was "custodial" in nature (an express exclusion from Plan coverage).

Petitioners then filed an action in California state court in July 1993 seeking to recover 100% of the amount they had paid for 24-hour care. After respondent removed the action to the United States District Court for the Central District of California, the parties filed cross-motions for summary judgment. The district court granted petitioners' motion and denied respondent's

motion. Although it concluded that the Plan Administrator's interpretation of "custodial" was reasonable, App. 19, the district court held that because it felt that term was ambiguous, the doctrines of *contra proferentem* and "reasonable expectations" required the Plan Administrator to accept the contrary interpretation proffered by petitioners.

Respondent Plan appealed to the United States Court of Appeals for the Ninth Circuit. In an unpublished memorandum decision filed March 13, 1997, a Ninth Circuit panel unanimously reversed the district court and remanded with instructions to enter summary judgment for the Plan. App. 1-2. The panel succinctly held that, because the Plan is self-funded and expressly delegates to the Plan Administrator the right to interpret ambiguous provisions, the district court had improperly applied the doctrines of *contra proferentem* and reasonable expectations to the Plan's custodial care exclusion and should have deferred to the Plan Administrator's reasonable interpretation of the provision. App. 1-2.

The panel also concluded that the district court should have deferred to the administrator's reasonable conclusion, supported by medical evidence in the record, that 24-hour nursing care for Mrs. Bjurman was not medically necessary. App. 2.

The panel on April 25, 1997 denied a petition for rehearing and advised petitioners that no active judge of the full court had requested a vote on petitioners' suggestion for a rehearing en banc. App. 3.

II. STATEMENT OF FACTS

Dorothy Bjurman was a beneficiary of the Transamerica Corporation Employees Health Care Plan (the "Plan") through her late husband, a former Transamerica executive.

The Plan designates the Transamerica Corporation Benefits Administration Committee (the "Committee") to carry out Transamerica's role as Plan Administrator. The Plan delegates discretionary authority to the Committee to, among other things, "interpret the provisions of the Plan and to determine any question arising under, or in connection with the administration or operation of, the Plan." ER 54-55. The Plan further provides that "all decisions of the Committee, and any action taken by it in respect of the Plan and within the powers granted to it under the Plan, shall be conclusive and binding on all persons." ER 56.

The Plan covers "home health care" expense in certain circumstances, providing in conspicuously-placed language that:

- "Home health care does not include housekeeping or custodial care." ER 106-07
- "Covered Expense does not include . . . Expense for custodial care, except when provided by a Hospice." ER 109
- "Please note: Home health care must be medically necessary and prescribed by a doctor. It does not include custodial care such as feeding, bathing, or administering medication." ER 282.

In April 1992, Mrs. Bjurman was released from the hospital following surgery. Her daughter, petitioner Susan Bjurman, promptly retained a private-duty nursing agency to provide 24-hour nursing services to Mrs. Bjurman at home while Susan Bjurman worked. ER 370-71. A series of treatment plans from Mrs. Bjurman's doctor outlined a variety of assessment and monitoring functions for the nurses to perform. ER 424-25, 450-51, 609-10. With the exception of several intermittent hospitalizations, the 24-hour-a-day private nursing services continued until Mrs. Bjurman's final hospitalization in December 1992.

The nursing agency first requested authorization for 24-hour home nursing care from the Plan's claims administrator, Prudential Health Care, in late June 1992. ER 426. Prudential promptly responded that coverage for continuing nursing care would probably be denied because the activities specified by Mrs. Bjurman's doctor appeared to be custodial, and the Plan excluded custodial care. ER 432. After obtaining additional information from Mrs. Bjurman's doctor and the hospital, and reviewing the detailed nursing notes that documented the care actually being provided by the private duty nurses, Prudential's medical staff (including five different professionals) concluded that most of the 24-hour care was custodial in nature and not medically necessary, but that intermittent R.N. visits would be authorized to attend to any "medically necessary" needs. ER 496-97, 526, 536, 538, 560-69, 598-99, 601-02, 651-52.

Petitioners appealed Prudential's August 1992 denial to the Plan Committee. ER 606. The Committee's secretary requested that Prudential's Regional Appeals Committee examine the claim and report to the Committee. ER 657. After reviewing hundreds of pages of nursing notes, the Prudential doctors again concluded that most of the services rendered to Mrs. Bjurman were custodial and not medically necessary. ER 670.

Prudential sent a detailed letter to the Plan Committee recapping the entire chronology of the claim. ER 666-71. The manager of Prudential's Claim Technical Services Division then met with the full Plan Committee to further review the claim. ER 679-80. The Committee's minutes reflect that, "after extensive discussion, the Committee agreed that the care provided to Mrs. Dorothy Bjurman was primarily custodial care and therefore expressly excluded under the [Plan]. The Committee agreed with Prudential's recommendation to provide benefits for three visits per week by an R.N. during the period when Mrs. Bjurman was not hospitalized." ER 680. After the denial of a further appeal to the Committee, this lawsuit followed.

REASONS FOR DENYING THE WRIT

I. PETITIONERS FAILED TO RAISE IN THE COURT OF APPEALS ANY OF THE THREE QUESTIONS RELATING TO A 1989 SPD THAT THEY SEEK TO PRESENT BY THEIR PETITION TO THIS COURT

Petitioners, after citing the portions of ERISA that govern the content of a summary plan description

("SPD"), seek to present three questions for this Court's review regarding interpretation of what they call "an ambiguous exclusionary term contained in a SPD." Pet. at i. Throughout their petition, petitioners argue that the SPD they have in mind is a January 1989 supplement they call the "1989 SPD." Pet. at 3-4, 5-6, 13, 17-18.

No aspect of these questions was presented to the court of appeals. In their brief, petitioners nowhere cited any ERISA provision relating to SPDs. Nowhere did they argue to the court of appeals that the Plan Administrator here in any way violated the SPD provisions of ERISA.[1] Most significantly, nowhere did they even bring to the attention of the court of appeals the 1989 SPD they now ask this Court to review. Instead, petitioners' argument to the court of appeals focused entirely on interpretation of language found in the ***Plan*** and not in ***any*** SPD, much less the 1989 version on which they now seek to rely. *See* Br. of Appellees filed March 18, 1996 at 29.[2]

Petitioners' failure to raise these issues in the court of appeals precludes their belated effort to present them for review by this Court. *See Delta Air Lines, Inc.* v. *August*, 450 U.S. 346, 362 (1981) (question presented in petition but not raised in court of appeals "is not properly before us").

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[1] The district court had expressly declined to reach this issue. App. 16-17 at n.7.

[2] Petitioners' argument to the court of appeals was also silent as to all other aspects of the "Medicare" argument they now seek to present for this Court's review in their third question. Pet. at i, 17-18.

II. THE PLAN ADMINISTRATOR'S DETERMINATION OF PETITIONERS' CLAIM TURNED ON UNIQUE FACTS, NOT ON ANY IMPORTANT OR RECURRING LEGAL ISSUE THAT MERITS THIS COURT'S REVIEW

Petitioners' expression of their case has undergone a remarkable metamorphosis since they argued it to the court of appeals. As they told the court below, "Plaintiffs have stressed throughout this litigation that this is a ***fact-intensive*** case." Br. of Appellees at 5 (emphasis added). They went out of their way to "reiterate that the ***unique facts*** of this case are of ***critical import***. . . . " *Id.* (emphasis added). They did not finish reciting those "unique facts" until page 23 of their 35-page brief.

Now, however, with the case having been decided adversely to them, petitioners hope to walk away from the "unique facts" that compelled that result. Instead, they attempt to manufacture a supposed conflict among the circuits by relying on cases they never mentioned in the court of appeals and proclaiming that there is an "eminent need for uniformity of law." Pet. at 12.

In points III and IV below, we debunk the suggestion that petitioners' newly-cited cases in fact reveal any conflict among the circuits. But even if there were a conflict regarding application of the insurance doctrines of *contra proferentem* and "reasonable expectations" to the interpretation of ambiguous language in a self-funded ERISA plan that gives its administrator discretion over plan interpretation, it would be a tempest in a teapot. Resolution of petitioners' claims by the Plan Administrator turned entirely on the "unique facts" petitioners argued

at length to the court of appeals, and not on any interpretation of Plan language.

There was no dispute before the Plan Administrator as to what the term "custodial" ***meant***. The dispute centered on the nature of the nursing services Mrs. Bjurman received and whether anything beyond intermittent nursing visits was required to satisfy her "medically necessary," non-custodial needs.

The Plan Committee relied on the opinions of five different medical professionals on Prudential's staff in concluding that three nursing visits per week were sufficient to meet Mrs. Bjurman's medical needs and that the balance of the care prescribed for her was custodial.[3]

Under this Court's decision in *Firestone Tire and Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), and its progeny, the Plan Administrator's review of the medical evidence was within its discretion and may not be disturbed where it is supported by substantial medical evidence. Here, the court of appeals was entirely correct in holding that

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[3] Appellate decisions throughout the country have routinely upheld plan administrator decisions as to whether nursing services are "medically necessary" or "custodial" in circumstances like those here. *See, e.g., O'Connor* v. *Central Virginia U.F.C.W.*, 945 F.2d 799 (4th Cir. 1991); *Cathey* v. *Dow Chemical Co. Med. Care Program*, 907 F.2d 554 (5th Cir. 1990), *cert. denied*, 498 U.S. 1087 (1991); *Chambers* v. *Family Health Plan Corp.*, 100 F.3d 818 (10th Cir. 1996); *Birdsell* v. *United Parcel Service*, 94 F.3d 1130 (8th Cir. 1996); *Wald* v. *Southwestern Bell etc. Plan*, 83 F.2d 1002 (8th Cir. 1996); *Maune* v. *IBEW, Local No. 1 etc. Fund*, 83 F.3d 959 (8th Cir. 1996); *Buttram* v. *Central States etc. Fund*, 76 F.3d 896 (8th Cir. 1996).

"while there was a conflict in the medical evidence presented by the parties, the plan's doctors considered and rejected the medical necessity of around-the-clock care to protect Bjurman against the risk of aspiration and other complications. *E.g.*, ER at 659. We must defer to this reasonable conclusion. *See Barnett* v. *Kaiser Foundation Health Plan, Inc.*, 32 F.3d 413, 417 (9th Cir. 1994). And we do." App. 2.

That conclusion of law, compelled by the record and the *Firestone* standard of review, renders entirely irrelevant the questions petitioners seek to present for this Court's review.

III. THERE IS NO CONFLICT AMONG THE CIRCUITS ON THE QUESTION WHETHER A PLAN ADMINISTRATOR'S EXPRESS DISCRETION TO INTERPRET AMBIGUOUS TERMS IN A SELF-FUNDED PLAN CAN BE OVERRIDDEN BY A BENEFICIARY'S CLAIM OF "REASONABLE EXPECTATIONS."

Petitioners attempt to argue that the fundamental rule embodied in *Firestone* v. *Bruch* and its progeny – that the interpretation or application of plan language by a plan administrator having full discretionary authority to do so is entitled to deference and should be upheld unless arbitrary and capricious – should be ignored where a plan beneficiary claims a "reasonable expectation" of a different result. They rely on cases holding that ambiguous terms in insurance policies should be interpreted in a manner consistent with the reasonable expectations of the insured.

As the court of appeals held in this case, because the self-funded plan at issue "expressly delegates to plan administrators the right to interpret ambiguous provisions," App. 1, "the district court should have deferred to the plan committee's reasonable interpretation" of its coverage provisions. *Winters* v. *Costco Wholesale Corp.*, 49 F.3d 550, 553 (9th Cir.), *cert. denied*, 116 S.Ct. 276 (1995). App. 2.

Petitioners argue that both *Winters* and cases from other circuits apply the doctrine of "reasonable expectations" to self-funded plans that confer discretionary authority on plan administrators. Pet. at 10-12. They are wrong.

In *Winters*, the Ninth Circuit made clear that its earlier decision in *Saltarelli* v. *Bob Baker Group Medical Trust*, 35 F.3d 382 (9th Cir. 1994), applied the "reasonable expectations" doctrine only in the insurance context, noting that the *Saltarelli* court held that "the doctrine of reasonable expectations applies as a principal of federal common law controlling interpretation of ERISA-governed ***insurance contracts***." 49 F.3d at 554 (emphasis added). *See also, Peterson* v. *American Life & Health Ins. Co.*, 48 F.3d 404, 411 (9th Cir. 1995) (*Saltarelli* applies "only when a provision in an insurance policy is either ambiguous or not sufficiently conspicuous"); *Babikian* v. *Paul Revere Life Ins. Co.*, 63 F.3d 837, 842 (9th Cir. 1995) (*Saltarelli* involved insurance policy interpretation and does not apply where an insurance policy exclusion is conspicuous).

Moreover, as the Ninth Circuit recently said in *Snow* v. *Standard Ins. Co.*, 87 F.3d 327, 330 n.1 (9th Cir. 1996), the doctrine of reasonable expectations cannot be used to

strip a plan administrator of discretion even in an ERISA-governed ***insurance*** plan.

Nor do the cases petitioners cite from other circuits take a contrary view. In *Mitchell* v. *Eastman Kodak Co.*, 113 F.3d 433, 443 (3d Cir. 1997), the issue was not plan ambiguity, but imposition by the plan administrator of a requirement (clinical evidence of etiology for chronic fatigue syndrome) nowhere found in the plan. No resort to the insurance doctrine of "reasonable expectations" is necessary to conclude that a plan administrator's discretion does not extend to making up new requirements that are absent from the plan's language.

In *Bailey* v. *Blue Cross & Blue Shield*, 67 F.3d 53, 57 (4th Cir. 1995), the doctrine of "reasonable expectations" was applied to an insurance policy, not a self-funded plan, and the court applied a less deferential standard of review because the insurer had an obvious conflict of interest. Similarly, *Wheeler* v. *Dynamic Engineering, Inc.*, 62 F.3d 634, 638 (4th Cir. 1995), involved an insured plan,[4] and the court expressly applied a *de novo* standard of review because the plan gave the plan administrator no discretion. *Id.* at 638.

Finally, in *Lutheran Med. Ctr.* v. *Contractors Health Plan*, 25 F.3d 616, 621 (8th Cir. 1994), the court held that a summary plan description saying that mental disorders are covered created an expectation of coverage for

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[4] Petitioners erroneously claim that the plan in *Wheeler* was self-funded. Pet. at 11. Although initially self-funded, the plan in *Wheeler* was reinsured, 62 F.3d at 637, and the court repeatedly referred to the plan as "insurance" and the beneficiaries as "insureds." *Id.* at 638-40.

depression, such that the plan administrator could not refuse to pay for treatment for depression merely because it deemed plaintiff a suicide risk and the plan excluded coverage for suicide attempts. Thus the case turned on clear language in an SPD, not ambiguous language in a plan.[5]

In sum, none of the cases on which petitioners rely contain support for their plea that this Court abandon *Firestone* and hereafter allow a plan administrator's express discretion to interpret ambiguous plan language to be undermined by a beneficiary's claimed expectation of a different interpretation.

IV. THERE IS NO CONFLICT AMONG THE CIRCUITS ON THE QUESTION WHETHER A PLAN ADMINISTRATOR'S EXPRESS DISCRETION TO INTERPRET AMBIGUOUS TERMS IN A SELF-FUNDED PLAN CAN BE OVERRIDDEN BY THE INSURANCE DOCTRINE OF *CONTRA PROFERENTEM*

Petitioners also seek to argue that the insurance doctrine of *contra proferentem* – construing ambiguous provisions of insurance policies against the insurer – should be applied to self-funded plans as well, even where the plan

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[5] Moreover, the Eighth Circuit has recently and repeatedly upheld plan administrators' decisions that, like that here, are based on their own medical opinions regarding medical necessity or custodial care, notwithstanding the contrary opinion of a beneficiary's physicians. *See, e.g, Birdsell* v. *UPS, supra,* 94 F.3d at 1131-32; *Wald* v. *Southwestern Bell, supra,* 83 F.3d at 1008; *Maune* v. *IBEW, supra,* 83 F.3d at 963; *Buttram* v. *Central States, supra,* 76 F.3d at 902 *n.*9.

gives full discretion to the plan administrator to interpret ambiguous terms. Pet. at 14-16. Again, petitioners miss the mark.

They begin by citing the Ninth Circuit's opinion in *Kunin* v. *Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990) as the "seminal decision" regarding application of *contra proferentem* in ERISA cases. Pet. at 14. *Kunin*, however, involved an insurance policy, and the Ninth Circuit's subsequent decisions have repeatedly made clear that the doctrine does not apply to either self-funded plans[6] ***or*** to plans that give discretion over plan interpretation to the plan administrator.[7] Where a plan is ***both*** self-funded ***and*** confers discretion on the plan administrator, as in this case, it is doubly impermissible to rely on *contra proferentem* to limit or eliminate the plan administrator's discretion.

Although petitioners attempt to suggest that other circuits disagree with the Ninth Circuit, the cases they cite demonstrate the contrary. In *Collins* v. *American Cast Iron Pipe Co.*, 105 F.3d 1368, 1371 (11th Cir. 1997), the court ***reversed*** a judgment for plaintiff that had been based on alleged ambiguity as between a plan and an

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[6] *Eley* v. *Boeing Co.*, 945 F.2d 276, 280 (9th Cir. 1991); *Winters* v. *Costco*, *supra*, 49 F.3d 550, 554 (9th Cir. 1995).

[7] *Snow* v. *Standard Ins. Co.*, *supra*, 87 F.3d at 330 *n.*1 (*contra proferentem* cannot be used to strip a plan administrator of discretion even in an insured plan); *Winters*, *supra*, 49 F.3d at 554; *Atwood* v. *Newmont Gold Co.*, 45 F.3d 1317, 1324 (9th Cir. 1995)(application of *contra proferentem* would "completely do away with the abuse of discretion standard we must apply").

SPD.[8] It cited its earlier decision in *Lee* v. *Blue Cross, etc.*, 10 F.3d 1547 (11th Cir. 1994), as the basis of plaintiff's *contra proferentem* argument, but *Lee* was expressly limited to insurance contracts. *Id.* at 1557. In *Nightingale* v. *Blue Cross*, 41 F.3d 1476, 1481 (11th Cir.), *cert. denied*, 115 S.Ct. 2002 (1995), the court applied a *de novo* standard of review and cited its earlier decision in the insurance context of *Lee* as the basis for application of *contra proferentem*.

In *Doe* v. *Group Hosp. & Med. Services*, 3 F.3d 80, 89 (4th Cir. 1993), the court likewise dealt only with an insured plan and relied only on cases dealing with insurance policies. In *Heasley* v. *Belden & Blake Corp.*, 2 F.3d 1249, 1258 (3d Cir. 1993), the court examined *contra proferentem* only in determining whether the plan conferred discretion on the plan administrator sufficiently clearly to warrant a deferential standard of review, and noted that it had declined to apply *contra proferentem* in non-insurance ERISA cases. *Id.* at 1257.

Finally, the court in *Germany* v. *Op. Eng. Trust Fund*, 789 F. Supp. 1165 (D.D.C. 1992), confirmed that under a deferential standard of review "it is for the trustees, and

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[8] Similarly in *Wahlin* v. *Sears, Roebuck & Co.*, 78 F.3d 1232 (7th Cir. 1996), the court of appeals ***reversed*** a district court judgment for plaintiff, finding that there were no ambiguous plan terms that would allow the court to "construe them in favor of the insured" as in the insurance cases it cited. *Id.* at 1235. Relying on *Winters, supra*, the Seventh Circuit has subsequently held that *contra proferentem* is inapplicable where, as here, a plan administrator has discretionary authority to construe plan terms. *Morton v. Smith*, 91 F.3d 867, 871 n.1 (7th Cir. 1996).

not the courts, to choose between two reasonable alternatives" in interpreting plan language. *Id.* at 1167. The court declined to defer to the plan administrator only in interpreting the ERISA statute itself. *Id.*

In sum, petitioners' cases entirely belie their claim of a "confounded state of the law." Pet. at 17. No court has applied *contra proferentem* to strip a plan administrator of discretion to interpret ambiguous plan terms where, as here, such discretion is conferred by the terms of a self-funded plan.

CONCLUSION

For the reasons given above, respondent respectfully requests that the petition be denied.

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